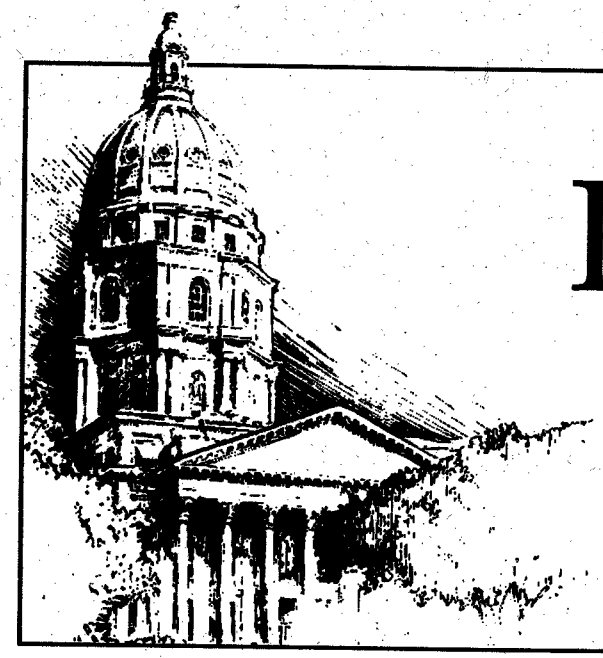

Kansas Register

Bill Graves, Secretary of State

Vol. 10, No. 37 September 12, 1991 Pages 1337-1396

In this issue . . .

State of Kansas

Kansas Inc.

Notice of Meeting

The Kansas Inc. board will meet at 1 p.m. Thursday, September 19, in the Visibility Room of The Boeing Company Headquarters, Wichita. The meeting is open to the public.

Charles R. Warren
President

Doc. No. 011060

State of Kansas

Board of Accountancy

Notice of Meeting and Administrative Hearing

The Board of Accountancy will hold a regularly scheduled meeting at 9 a.m. Tuesday, September 24, in Conference Room 108, Landon State Office Building, 900 S.W. Jackson, Topeka. Persons interested in agenda items or in attending should contact the board office in Suite 556 of the Landon Building.

In addition, the board will conduct an administrative hearing in the matter of James Ray Cruce, CPA, at 2 p.m. at the same location.

Glenda Moore
Executive Director

Doc. No. 011068

State of Kansas

Department of Commerce

Notice Concerning 1991 Comprehensive Housing Affordability Strategy

As part of the Cranston-Gonzalez National Affordable Housing Act of 1990, all states are required to write a comprehensive housing affordability strategy (CHAS), which is a comprehensive plan containing housing conditions, needs and priorities within the state of Kansas. The plan is composed of three sections: market and housing conditions, a five-year strategy, and a one-year plan. The CHAS is available at all county clerk's offices throughout the state and at all Regents university libraries.

The State Office of Housing will be conducting public hearings on the following dates:

—9 a.m. September 25
Garden City Community College, Garden City
Warren Fouse Science and Math Building
Science Lecture Hall

—3 p.m. September 25
Fort Hays State University, Hays
Memorial Union, Trails Room

—2 p.m. September 26, 1991
Butler County Community College, El Dorado
Student Union, Purple & Gold Room

—10 a.m. September 30
State Capitol, Topeka
Room 526-S

Laura E. Nicholl
Secretary of Commerce

Doc. No. 011071

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State of Kansas

Kansas Council on Employment and Training

Notice of Meeting

The Kansas Council on Employment and Training will meet from 1:30 to 5 p.m. Wednesday, September 25, and from 8:30 to noon Thursday, September 26, at the Holiday Inn City Centre, 914 S.E. Madison, Topeka. The meetings are open to the public.

Joe Dick
Secretary of Human Resources

Doc. No. 011074

State of Kansas

Kansas Technology Enterprise Corporation

Notice of Meeting

The Mid-America Manufacturing Technology Center Board of Directors will meet at 10 a.m. Monday, September 16, at the Johnson County Community College, Cultural Education Center, Room 232, 12345 College at Quivira, Overland Park.

Carol Wiebe
Chairman, KTEC

Doc. No. 011075

State of Kansas

Office of the Governor

Executive Order No. 91-143

Establishing the Governor's Task Force for a Classification Amendment

WHEREAS, the Kansas property tax system contains inherent structural inequities;

WHEREAS, amending the constitutional provisions pertaining to the classification of property provides a mechanism to address these inherent structural inequities;

WHEREAS, there is a compelling need for careful study to fashion a classification amendment that addresses the inequities Kansas property taxpayers face;

NOW THEREFORE, pursuant to the authority vested in me as the Governor of the State of Kansas, I hereby establish the Governor's Task Force for a Classification Amendment.

The Task Force shall submit a report and its recommendations for a constitutional amendment pertaining to property classification by January of 1992.

Membership on the Governor's Task Force for a Classification Amendment shall be by official certificate of appointment of the Governor, certified by and filed with the Secretary of State. The chairmanship of the Task Force shall be designated by official certificate of appointment of the Governor, certified by and filed with the Secretary of State.

Members of the Task Force shall serve without compensation. The Department of Revenue (DOR) shall pay Task Force members mileage and subsistence payments in accordance with K.S.A. 75-3223 for attendance at authorized meetings and subcommittee meetings of the Task Force.

This document shall be filed with the Secretary of State as Executive Order No. 91-143 and shall become effective immediately.

Dated August 29, 1991.

Joan Finney
Governor
Attest: Bill Graves
Secretary of State

Doc. No. 011061

State of Kansas

Office of the Governor

Executive Order No. 91-144

Implementing Percentage Reductions Pursuant to K.S.A. 1990 Supp. 75-6704

WHEREAS, pursuant to K.S.A. 1990 Supp. 75-6704, the director of budget has estimated that for fiscal year 1992, the unencumbered ending balance in the State General Fund, plus the unencumbered balance in the State Cash Operating Reserve Fund, will be less than $100 million;

WHEREAS, the director of the budget has certified that $26,149,238 is the amount of difference between $100 million and the June 30, 1992, estimated unencumbered balance in the State General Fund and State Cash Operating Reserve Fund;

WHEREAS, the State Finance Council has approved a 1.0% reduction in accordance with K.S.A. 1990 Supp. 75-6704;

NOW THEREFORE, under the authority vested in me as Governor of the State of Kansas, I hereby issue this Executive Order providing for a 1.0% reduction to: (1) the amount authorized to be expended from each appropriation from the State General Fund for the current fiscal year, other than any item of appropriation for debt service for payments pursuant to contractual bond obligations or any item of appropriations for employer contributions for the employers who are eligible employers as specified in subsections (1), (2) and (3) of K.S.A. 74-4931 and amendments thereto under the Kansas public employees retirement system pursuant to K.S.A. 74-4939 and amendments thereto, and (2) the amount of each demand transfer from the State General Fund for the current fiscal year.

This document shall be filed with the Secretary of State as Executive Order No. 91-144 and shall become effective immediately.

Dated August 30, 1991.

Joan Finney
Governor
Attest: Bill Graves
Secretary of State

Doc. No. 011062

State of Kansas

Department of Administration

Public Notice

Under requirements of K.S.A. 1990 Supp. 65-34,117(b), records of the Division of Accounts and Reports show the unobligated balance in the petroleum storage tank release trust fund is $7,066,142.78 at August 31, 1991.

James R. Cobler
Secretary of Administration

Doc. No. 011078

State of Kansas

Kansas State University

Notice to Bidders

Sealed bids for the items listed below will be received by the Kansas State University Purchasing Office, Manhattan, until 2 p.m. local time on the date indicated and then will be publicly opened. Interested bidders may call (913) 532-6214 or FAX (913) 532-5632 for additional information.

Tuesday, September 24, 1991
#20026
Photosynthesis measurement system
and other plant measurement devices

William H. Sesler
Director of Purchasing

Doc. No. 011070

(Published in the Kansas Register, September 12, 1991.)

Summary Notice of Bond Sale
City of Coats, Kansas
$150,000
General Obligation Bonds, Series 1991
(general obligation bonds payable from unlimited ad valorem taxes)

Sealed Bids

Subject to the notice of bond sale and preliminary official statement dated August 29, 1991, sealed bids will be received by the city clerk of Coats, Kansas (the issuer), on behalf of the governing body at the Coats City Hall until 2 p.m. C.D.T. September 19, 1991, for the purchase of $150,000 principal amount of General Obligation Bonds, Series 1991. No bid of less than the entire par value of the bonds and accrued interest thereon to the date of delivery will be considered.

Bond Details

The bonds will consist of fully registered bonds in the denomination of $5,000 or any integral multiple thereof. The bonds will be dated September 1, 1991, and will become due on September 1 in the years as follows:

Year	Principal Amount
1993	$ 5,000
1994	5,000
1995	5,000
1996	5,000
1997	5,000
1998	5,000
1999	5,000
2000	5,000
2001	5,000
2002	5,000
2003	5,000
2004	5,000
2005	10,000
2006	10,000
2007	10,000
2008	10,000
2009	10,000
2010	10,000
2011	15,000
2012	15,000

The bonds will bear interest from the date thereof at rates to be determined when the bonds are sold as hereinafter provided, which interest will be payable semiannually on March 1 and September 1 in each year, beginning on March 1, 1993.

Paying Agent and Bond Registrar

Kansas State Treasurer, Topeka, Kansas.

Good Faith Deposit

Each bid shall be accompanied by a cashier's or certified check drawn on a bank located in the United States of America in the amount of $3,000 (2 percent of the principal amount of the bonds).

Delivery

The issuer will pay for printing the bonds and will deliver the same properly prepared, executed and registered without cost to the successful bidder on or about September 30, 1991, at such bank or trust company as may be specified by the successful bidder.

Assessed Valuation and Indebtedness

The equalized assessed tangible valuation for computation of bonded debt limitations for the year 1990 is $291,695. The total general obligation indebtedness of the issuer as of the date of the bonds, including the bonds being sold, is $200,000.

Approval of Bonds

The bonds will be sold subject to the legal opinion of Gilmore & Bell, Wichita, Kansas, bond counsel, whose approving legal opinion as to the validity of the bonds will be furnished and paid for by the issuer, printed on the bonds and delivered to the successful bidder as and when the bonds are delivered.

Additional Information

Additional information regarding the bonds may be obtained from the clerk, (316) 893-2310, or from the financial advisor, Hanifen, Imhoff, Inc., Lakeside Plaza Building, 250 S. Rock Road, Suite 213, Wichita, KS 67206, Attention: Mr. Gale W. Doner (316/682-1001).

Dated August 29, 1991.

City of Coats, Kansas

Doc. No. 011077

State of Kansas

Department of Administration
Division of Purchases

Notice to Bidders

Sealed bids for the purchase of the following items will be received by the Director of Purchases, Landon State Office Building, 900 S.W. Jackson, Room 102, Topeka, until 2 p.m. C.D.T. on the date indicated and then will be publicly opened. Interested bidders may call (913) 296-2377 for additional information.

Monday, September 23, 1991

27378
Larned State Hospital—Pest control service

28587
Statewide—Two-way radio equipment

89741
Department of Transportation—Concrete

89742
Department of Transportation—Steel posts

89789
Department of Health and Environment—System development on IBM AS/400 system

Tuesday, September 24, 1991

A-6786
Department of Corrections—Wichita work release facility reroof

27341
Statewide—Institutional clothing

27567a
Statewide—Single line telephones

27866
Kansas State University—Lab services/clinical and pathology

89743
Kansas Correctional Industries—Punch press

89804
Adjutant General's Department—Furnish and install metal building

89805
Adjutant General's Department—Construct concrete ramp, Fort Riley

89806
Adjutant General's Department—Construct office area and restrooms, United States Property and Fiscal Office, Topeka

Wednesday, September 25, 1991

A-6702
Youth Center at Topeka—Replace steam coils and piping, Shawnee and Pawnee cottages

A-6783
Department of Wildlife and Parks—Ford County Lake renovation project

27474
University of Kansas Medical Center—November (1991) meat products

27524
University of Kansas—November (1991) meat products

89753
Kansas State University—Steam coils

89757
Pittsburg State University—Disk drivers

89761
Kansas State University—IDMS data base journal file reformatting and organizing utility

Thursday, September 26, 1991

A-6363
University of Kansas—Lied Center site development

A-6707
Youth Center at Beloit—Resurface existing asphalt roads and parking lots

28585
Department of Corrections—Elevator and dumbwaiter service, Lansing

28586
Kansas Bureau of Investigation—Maintenance of building environmental system

89776
Kansas State School for the Visually Handicapped—Furnish all labor and materials for excavating and concrete walls

Friday, September 27, 1991

28584
Statewide—Facsimile paper

89785
Kansas Correctional Industries—Cold rolled steel sheets

89786
Department of Transportation—Furnish and install overhead crane, Olathe

Tuesday, October 1, 1991

89732
University of Kansas—Scientific workstation

89733
Department of Social and Rehabilitation Services—Expanded memory/IBM 3090-400E mainframe

Wednesday, October 2, 1991

A-6769
Department of Administration—Interior renovation, Kansas Judicial Center (Appellate judges/Attorney General's office)

A-6770
Department of Administration—Interior renovation, State Capitol, Room 263-E

Tuesday, October 8, 1991

89778
Department of Social and Rehabilitation Services—Data general peripherals and components

****

Request for Proposals

Monday, September 23, 1991

28590
Family preservation consulting services for the Department of Social and Rehabilitation Services

Monday, October 7, 1991

28456
Emergency response and hazardous waste disposal services for the Kansas Bureau of Investigation

Leo E. Vogel
Acting Director of Purchases

Doc. No. 011073

State of Kansas

Attorney General

Opinion No. 91-98

Counties and County Officers—Sheriff—Deputies and Undersheriffs; Limitation of Personnel Action.

Cities of the Second Class; Commission Government—The Board of Commissioners—Mayor or Commissioner Holding Other Office; Incompatibility of Offices. Representative Don Rezac, 61st District, Emmett, August 28, 1991.

K.S.A. 19-805d provides that a sheriff in deciding personnel issues is subject to the personnel policies and procedures established by the board of county commissioners. A person may not serve simultaneously as a city commissioner and a deputy sheriff pursuant to the prohibitions of K.S.A. 14-1302. Cited herein: K.S.A. 14-1302; 19-805d. MJS

Opinion No. 91-99

Constitution of the State of Kansas—Apportionment of the Legislature—Reapportionment of Senatorial and Representative Districts; Census. Senator Ben Vidricksen, 24th District, Salina, August 28, 1991.

In reapportioning the senatorial and representative districts during its regular session in 1992, the Legislature is obligated under section 1 of article 10 of the Kansas constitution to use those population figures approved and certified by the Census Bureau of the United States. Because the Census Bureau has rejected those figures contained in the post enumeration survey, the Legislature is not permitted to adjust federal census figures based on information provided in the post enumeration survey. Cited herein: Kan. Const., art. 10, § 1. RDS

Opinion No. 91-100

Taxation—Aggregate Tax Levy Limitations—County Extension Council Employee Benefit Plan Expenses. Ted D. Ayres, General Counsel, Kansas Board of Regents, Topeka, August 28, 1991.

Levies for county extension council employee benefit plan expenses are exempted from the limitations of K.S.A. 79-5021 *et seq.*, and amounts produced from such levies should not be considered in computing the county's aggregate limitation. Cited herein: K.S.A. 1990 Supp. 79-5022; 79-5028; 79-5032. JLM

Opinion No. 91-101

Public Utilities—Powers of State Corporation Commission; Gas Pipeline Safety—Rules and Regulations in Conformance with Federal Pipeline Safety Act; Application. Jim Robinson, Chairman, Kansas Corporation Commission; Joe Norton, Counsel for the Kansas Municipal Gas Agency, Wichita, September 3, 1991.

K.S.A. 66-1,150 authorizes the Kansas Corporation Commission (KCC) to adopt rules and regulations in conformance with the natural gas pipeline safety act of 1968 (49 U.S.C. 1671 *et seq.*) Conformance with this act permits the KCC to impose more stringent regulations pursuant to state authority. The regulations promulgated apply to all public gas utilities, including municipalities that are otherwise outside the KCC's jurisdiction. Cited herein: K.S.A. 66-104; 66-1,150. GE

Opinion No. 91-102

State Institutions and Agencies; Historical Property—State Educational Institutions; Management and Operation—University Police Officers; Powers and Authority; Jurisdiction. Representative Sheila Hochhauser, 67th District, Manhattan, September 3, 1991.

If a university police officer views the commission of a crime in his territorial jurisdiction, he may pursue the suspect and cite or arrest him without a warrant outside of the officer's jurisdiction pursuant to his fresh pursuit authority. The officer may not, however, use his law enforcement powers to effect a warrantless arrest of the suspect for a crime viewed outside the officer's territorial jurisdiction, even if viewed after or during a lawful fresh pursuit stop. In such cases, the officer may make a citizen's arrest. Cited herein: K.S.A. 1990 Supp. 8-2104; 8-2106; K.S.A. 21-3105; 22-2401; 22-2401a; 22-2403; 76-726. JLM

Opinion No. 91-103

Public Health—Professional Counselors—Registration Required Prior to Certain Representations; Construction of Act.

State Boards, Commissions and Authorities—Crime Victims Compensation Board—Compensation for Crime Victims Economic Loss; Allowance Expense; Counseling Services Provided by Rabbi, Priest, Minister, or Clergy Person. Betty A. Bomar, Director, Crime Victims Compensation Board, Topeka, September 3, 1991.

Provided the activities or services of a rabbi, priest, minister, or clergy person are within the scope of the performance of such individual's regular or specialized ministerial duties, such individual need not be registered by the Behavioral Sciences Regulatory Board. The Crime Victims Compensation Board may accept as an allowance expense payable by the board a statement for counseling services provided by a rabbi, priest, minister, or clergy person who is not registered with the Behavioral Sciences Regulatory Board. Cited herein: K.S.A. 1990 Supp. 65-5801; 65-5803; 65-5804; 65-5812; 65-6301; 74-5301; 74-5361; 74-7301; 74-7302. RDS

Opinion No. 91-104

Schools—Organization, Powers and Finances of Boards of Education—Expenses of Board of Education Members; Non-Transferable Compensation Tickets. James L. Hargrove, Counsel for Unified School District No. 394, El Dorado, September 3, 1991.

A member of a board of education for a unified school district must incur an expense in order to receive payment from the school district. A board mem-

ber may not receive payment for a non-transferable compensation ticket used by the board member in the performance of official duties. Cited herein: K.S.A. 72-8202e; 72-8207. RDS

Robert T. Stephan
Attorney General

Doc. No. 011072

State of Kansas

Department of Transportation

Notice of Public Auction

The Kansas Secretary of Transportation will offer for sale at public auction at site at 10 a.m. October 17 the following platted tract of land described as R. E. Boxberger's Final Edition, a 2,418 sq. ft. office building and 3,745 sq. ft. service building, 4448 W. Kellogg, Wichita, northwest corner of Tracy and Kellogg Drive, south of the Towne West Square Shopping Center.

The removal of the underground storage tanks was under the supervision and approval of the Kansas Department of Health and Environment on July 15, 1988.

The Kansas Department of Transportation ensures the acceptance of any bid pursuant to this notice will be without discrimination on the grounds of sex, race, color, religion, physical handicap, or national origin.

Terms of the sale are money order or certified or cashier's check for full price. Make check payable to the Secretary of Transportation. The purchaser will receive a quitclaim deed. Title commitment for title insurance is available for review.

A payment option is a money order or a certified or cashier's check for 10 percent of the purchase price the day of the sale. The balance of the purchase price will be paid by money order or certified or cashier's check on or before November 17, 1991. If the balance is paid on or before said date, a quitclaim deed will be given to the successful bidder. If the balance of the purchase price is not paid on or before said date, the 10 percent down payment will be forfeited to the seller. Make checks payable to the Secretary of Transportation.

The seller reserves the right to reject any and all bids. For additional information contact Beverly Lee or Pamela Wolf, Bureau of Right of Way, Kansas Department of Transportation, (913) 296-3501.

Michael L. Johnston
Secretary of Transportation

Doc. No. 011076

State of Kansas

Department of Revenue
Division of Taxation

Public Notice

K.S.A. 79-3603(m) levies a tax "upon the gross receipts received from fees and charges by public and private clubs, drinking establishments, organizations and businesses for participation in sports, games and other recreational activities." Thus, fees charged for participation in a sport, game or recreational activity, such as league fees or tournament fees, would be subject to the Kansas retailers' sales tax. An organization which charges a fee for participation in one or more of these activities would be required to collect and remit the Kansas retailers' sales tax and any applicable local sales tax. These fees would be subject to the tax whether collected from each individual or on a team basis.

K.S.A. 79-3603(e) levies a tax "upon the gross receipts from the sale of admissions to any place providing amusement, entertainment or recreation services . . . but shall not be levied and collected upon the gross receipts received from fees and charges by political subdivisions of the state of Kansas for participation in sports, games and other recreational activities . . ." Therefore, fees charged for admission to sports, games or recreational activities (gate receipts) would be subject to the retailers' sales tax.

Additional examples of transactions conducted by a league, association or tournament organizer, which would be subject to the retailers' sales tax include, but are not limited to, the sale of food, soft drinks, candy, t-shirts, hats, balls, etc. The organizing group would also be required to collect and remit the retailers' sales tax on fund raising activities, such as the door-to-door sales of candy or similar items.

As stated in K.S.A. 79-3603(e), the charges made by political subdivisions of the state of Kansas for participation in sports, games and other recreational activities would not be subject to the retailers' sales tax (examples would include such activities as softball, baseball, volleyball, soccer, admissions to swimming pools, green fees, etc.). However, the political subdivision of the state of Kansas would be required to collect and remit the retailers' sales tax on the sales of tangible personal property, such as food, beverages, t-shirts, hats, balls, etc. and on the charges for admission to such sports, games and other recreational activities.

Alisa M. Dotson
Director of Taxation

Doc. No. 011064

State of Kansas

Department of Revenue
Division of Taxation

Public Notice

The Kansas Department of Revenue has been asked whether the federal excise tax, as provided for in the Internal Revenue Code, Section 4001 *et seq.*, should be part of the gross receipts subject to Kansas retailers' sales tax. K.S.A. 79-3603(a) imposes a tax at the rate of 4.25% upon the gross receipts received from the sale of tangible personal property at retail within this state.

K.S.A. 79-3602(h) defines "gross receipts" as the "total selling price or the amount received as defined in this act, in money, credits, property or other consideration valued in money from sales at retail within this state." Internal Revenue Code, Section 4001 *et seq.*, imposes a federal excise tax on the sale of passenger vehicles, heavy trucks and trailers, boats, aircraft, jewelry, furs.

The Kansas Department of Revenue has determined that the federal excise tax imposed on the sale of passenger vehicles, heavy trucks and trailers, boats, aircraft, jewelry, and furs should not be included in the gross receipts subject to Kansas retailers' sales tax, provided the tax is separately stated on the billing or invoice. This determination applies to all leases of passenger vehicles over one year in duration, and to all leases of boats and aircraft (IRC Sec 4011) regardless of the duration of the lease.

In cases of short term leases of passenger vehicles (less than one year), the federal excise tax shall be included in the gross receipts of the rental charge subject to the Kansas retailers' sales tax. The rational for this position is that the rental agency is considered to have made the first retail purchase upon which the federal excise tax is imposed, [IRC 4011(c)(1) & IRC 4011(c)(2)(B)(ii) and IRC 4052(f)]. Therefore, in cases of short term leases of passenger vehicles, the federal excise tax is on the retailer and not on the consumer. Kansas Administrative Regulation 92-19-55(f) is applicable to "taxes" on the retailer:

> K.A.R. 92-19-55(f). Sales tax shall be imposed on the total amount of each lease payment which the lessee is obligated under the contract to pay to the lessor for continued use of the tangible personal property, with no deduction or exclusion from the lease price for insurance, taxes, service or maintenance contracts, handling charges, administration charges, late fees, repair or service charges, or any other charges regardless of how any contract, invoice or other evidence of the transaction is stated or computed and whether separately billed or segregated on the same bill.

Thus, the federal excise tax and any charges associated with the financing of the federal excise tax are to be included in the gross receipts subject to Kansas retailers' sales tax in instances of short term leases of passenger vehicles.

Alisa M. Dotson
Director of Taxation

Doc. No. 011063

State of Kansas

Department of Revenue
Division of Taxation

Public Notice

The Kansas Department of Revenue has been asked whether electricity used to aerate grain by grain elevators would qualify for the Kansas retailers' sales tax exemption pursuant to K.S.A. 79-3606(n). K.S.A. 79-3603(a) imposes a sales tax at the rate of 4.25% upon the gross receipts received from the sale of tangible personal property at retail within this state. Therefore, unless specifically exempt, all sales of tangible personal property at retail in this state are subject to the Kansas retailers' sales tax.

K.S.A. 79-3606(n) exempts from sales tax "all sales of tangible personal property which is consumed in the production, manufacture, processing, mining, drilling, refining or compounding of tangible personal property, the providing of services or the irrigation of crops for ultimate sale at retail within or without the state of Kansas; and any purchaser of such property may obtain from the director of taxation and furnish to the supplier an exemption certificate number for tangible personal property for consumption in such production, manufacture, processing, mining, drilling, refining, compounding, irrigation and in providing such services."

Electricity is found within the definition of "property which is consumed in the production, manufacture, processing, mining, drilling, refining or compounding of tangible personal property," at K.S.A. 79-3602(m)(3)(B).

The Director of Taxation has determined that retail sales of electricity used to power fans, lifts, belts, etc., which are used to aerate grain, is not exempt from sales tax pursuant to K.S.A. 79-3606(n). Once the grain has been aerated, it still remains raw unprocessed grain, and as such, does not meet the statutory requirement of "property which is consumed."

Additional questions regarding this notice should be directed to the Kansas Department of Revenue, Tax Policy Group, Docking State Office Building, Topeka 66625-0001, (913) 296-5476.

Alisa M. Dotson
Director of Taxation

Doc. No. 011065

State of Kansas

Legislature

Interim Committee Schedule

The following committee meetings have been scheduled September 16 through September 29:

Date	Room	Time	Committee	Agenda
September 16 September 17 September 18	519-S 519-S 519-S	10:00 a.m. 9:00 a.m. 9:00 a.m.	Special Committee on Assessment and Taxation	16th: Proposal No. 2—Property Tax Abatements and Airports. 17th: Proposal No. 3—Local Consolidation. 18th: Proposal No. 4—Sales Tax Base.
September 16 September 17	514-S 514-S	10:00 a.m. 9:00 a.m.	Health Care Decisions for the 1990's	16th: Hearings—Representatives from American Medical Association; Kansas Academy of Family Physicians; Kansas AFL-CIO; Kansas Employer Coalition on Health; and American Nurses Association. 17th: Hearings—Representatives from Kansas Blue Cross/Blue Shield; Central-Kansas Assoc. of Health Underwriters; Sedgwick County Cost Containment Round Table; KDHE; and Kansas University.
September 16 September 17	313-S 313-S	10:00 a.m. 9:00 a.m.	Special Committee on Judiciary	Proposal No. 15—Judicial Administration.
September 18	527-S	10:00 a.m.	Apportionment Task Force	Agenda not available.
September 18 September 19	529-S 529-S	10:00 a.m. 9:00 a.m.	SRS Task Force Finance Subcommittee	Discussion and hearing on provider specific taxes; child support enforcement and child care funds.
September 19 September 20	531-N 531-N	10:00 a.m. 9:00 a.m.	Joint Committee on Special Claims Against the State	Hearings on claims filed to date.
September 19 September 20	514-S 514-S	10:00 a.m. 9:00 a.m.	Joint Committee on State Building Construction	19th: Presentations on proposed projects—Fort Hays State Univ., Dept. of Admin.; briefings and public comment on HB 2641. 20th: Project updates: KSU-S, COT and Univ. of Kansas; presentations on proposed projects—State Historical Society.
September 19 September 20	526-S 526-S	10:00 a.m. 9:00 a.m.	Legislative Educational Planning Committee	Agenda not available.
September 19 September 20	521-S 521-S	10:00 a.m. 9:00 a.m.	SRS Task Force Prevention Subcommittee	19th: Review of community based long-term care. 20th: Commerce discussion on preventive and primary health and alcohol and drug abuse services.

(continued)

September 23 September 24	519-S 519-S	10:00 a.m. 9:00 a.m.	Joint Committee on Economic Development	23rd: Presentations on enterprise zones. 24th: A.M.—Presentations related to incentives for businesses. 24th: P.M.—Committee discussion and possible recommendations on previously addressed topics.
September 23 September 24	529-S 529-S	10:30 a.m. 9:00 a.m.	SRS Task Force Long Term Care Subcommittee	Agenda not available.
September 26 September 27	514-S 514-S	10:00 a.m. 9:00 a.m.	Joint Committee on Administrative Rules and Regulations	Review rules and regulations filed by: Board of Agriculture; Secretary of Corrections; Kansas Racing Commission; Board of Education; Board of Pharmacy; Securities Commissioner; SRS; Dept. of Wildlife and Parks; Secretary of Aging; and KDHE.

Emil Lutz
Director of Legislative
Administrative Services

Doc. No. 011069

State of Kansas

Secretary of State

Executive Appointments

Executive appointments made by the Governor, and in some cases by other state officials, are filed with the Secretary of State's office.

Complete listings of state agencies, boards and commissions are included in the Kansas Directory. County officers are listed in the Directory of County Officers. Both directories are published by the Secretary of State's office.

The following appointments were filed September 3-6:

Chautauqua County Clerk

Lori Martin, Route 2, Box 120, Sedan 67361. Effective October 1, 1991. Term expires when a successor is elected and qualifies according to law. Succeeds Judith Brewer, resigned.

Children and Youth Advisory Committee

Ladislado Hernandez, 1136 S. Summit, El Dorado 67042. Term expires June 30, 1994. Succeeds Lana Oleen.

Dr. Grace Ketterman, 9231 Belinder, Leawood 66206. Term expires June 30, 1004. Succeeds Carolyn Clevenger Kuhn.

Rep. Kathryn Sughrue, 1809 La Mesa Drive, Dodge City 67801. Term expires June 30, 1993. Succeeds Patti Hayden.

Kansas Companion Animal Advisory Board

Marge Bradshaw, Public Member, 3910 Parlington, Topeka 66610. Term expires June 30, 1994.

Governor's Task Force for a Classification Amendment

(Established pursuant Executive Order No. 91-143. Members serve at the pleasure of the Governor.)

Lionel Alford, 14223 Northpoint, Wichita 67230.

Scott I. Asner, 10808 W. 109th, Overland Park 66210.

Mark V. Beshears, Secretary of Revenue, 2nd Floor, Docking State Office Building, Topeka 66612.

David Burress, 912 Holiday Drive, Lawrence 66048.

Rep. J. C. Long, 1309 Oak, Harper 67058.

Sen. Phil Martin, 403 W. Euclid, Pittsburg 66762.

Rep. Mike Sawyer, 1116 Dayton, Wichita 67213.

Sen. Dan Thiessen, Route 2, Box 22-48, Independence 67301.

Kansas Technology Enterprise Corporation

J. Wesley St. Clair, Commercial Banking Appointee, The Southgate Bank, 7600 State Line, Prairie Village 66208. Term expires April 13, 1995. Succeeds John M. Davis.

University of Kansas School of Medicine Admissions Committee

(Members serve at the pleasure of the Governor.)

Minnie Anderson, 1128 N. Grove, Wichita 67214.

Dan Carr, 131 S. 3rd, Lindsborg 67456.

Virginia Elmore, 321 S. High, Box 27, El Dorado 67042.

Marilyn Garr, 4421 W. 112th Terrace, Shawnee Mission 66221.

Elva Higgins, 406 W. Mission, St. Marys 66536.

Ruth Schrum, 720 Midland, Manhattan 66502.

Rep. Kathyrn Sughrue, 1809 La Mesa Drive, Dodge City 67801.

Evelyn Welton, 7426 Tauromee Ave., Kansas City 66112.

Bill Graves
Secretary of State

State of Kansas

Office of Judicial Administration

Court of Appeals Docket

(Note: Dates and times of arguments are subject to change.)

Kansas Court of Appeals
Court of Appeals Courtroom, 3rd Floor, Old Sedgwick County Courthouse
541 N. Main, Wichita, Kansas

Before Briscoe, C.J.; Rees, J.; and Barry A. Bennington, District Judge, assigned.

Tuesday, September 17, 1991

1:00 p.m.

Case No.	Case Name	Attorneys	County
66,332	In the Matter of the Trusteeship of the Will of Lester R. McDonald, deceased.	Dana P. Ryan Arthur B. McKinley	Seward
65,933	Ronald Lee Rhodes, Appellant, v. Robert D. Hannigan, *et al.*, Appellees.	Herbert R. Hess Ronald Rhodes, *pro se* Brian Johnson	Reno

2:00 p.m.

Case No.	Case Name	Attorneys	County
65,929	State of Kansas, Appellee, v. Kevin Johnson, Appellant.	Debra Byrd Wagner Attorney General Lucille Marino	Sedgwick
64,816	State of Kansas, Appellee, v. Elmer F. Johnson, Appellant.	Debra Byrd Wagner Attorney General Rebecca Woodman	Sedgwick
65,811	David R. Knittel, Appellant, v. State of Kansas, Appellee.	Elizabeth Sterns Attorney General County Attorney	Reno

Wednesday, September 18, 1991

9:00 a.m.

Case No.	Case Name	Attorneys	County
65,393	William R. and Nancy Karen Yoakum, Appellees, v. Calvin A. and Joyce A. Newman, Appellants.	Stephen B. Plummer Richard H. Rumsey James M. Munyon Charles E. Milsap Christopher A. McElgunn	Sedgwick
66,068	In the Matter of the Marriage of Connie J. Stevenson and Roy Gene Stevenson.	Michael G. Coash Richard C. King	Butler
65,766	State of Kansas, Appellee, v. Raymond Gonzalez, Appellant.	County Attorney Attorney General John F. Jones II	Harvey

(continued)

Summary Calendar—No Oral Argument

65,884	State of Kansas, Appellee, v. Gerald L. Smith, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
65,695	State of Kansas, Appellee, v. Brian L. Pouncil, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
64,932	State of Kansas, Appellee, v. Roger D. Tucker, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
65,969	State of Kansas, Appellee, v. Charles W. Dixon, Sr., Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
65,914	State of Kansas, Appellee, v. Anthony Vontress, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
65,151	State of Kansas, Appellee, v. Tommie A. Cameron, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick

Kansas Court of Appeals
Court of Appeals Courtroom, 2nd Floor, Kansas Judicial Center
Topeka, Kansas
Before Rulon, P.J.; Larson and Lewis, JJ.

Tuesday, September 17, 1991
9:30 a.m.

Case No.	Case Name	Attorneys	County
65,890	Gerald Oberer, Appellant, v. Topeka Correctional Facility, Appellee.	Cheryl D. Myers Timothy G. Madden	Shawnee
65,956	State of Kansas, Appellee, v. George Kirtdoll, Appellant.	Gene M. Olander Attorney General Rick Kittel	Shawnee
66,262	Sulaimon Hassan, Appellant, v. Reliable Car Shop, *et al.*, Appellees.	Sulaimon Hassan, *pro se* Jeary A. Seales Chris Miller	Shawnee

Summary Calendar—No Oral Argument

66,238	State of Kansas, Appellee, v. Maurice Gibson, Appellant.	Gene M. Olander Attorney General Jessica R. Kunen	Shawnee
66,129	State of Kansas, Appellee, v. Gerald C. Toledo, Appellant.	Gene M. Olander William K. Rork	Shawnee

Kansas Court of Appeals
Court of Appeals Courtroom, 2nd Floor, Kansas Judicial Center
Topeka, Kansas
Before Pierron, P.J.; Larson and Rulon, JJ.

Tuesday, September 17, 1991
1:30 p.m.

Case No.	Case Name	Attorneys	County
66,248	Central Pump and Supply, Inc., Appellee, v. American Fuel Transit, *et al.*, Appellants.	Robert K. Scovel Mark T. Lair Jon R. Viets	Montgomery
66,321	Professional Builders, Inc., Appellee, v. Sedan Floral, Inc., Appellant.	William J. Kelly Glenn E. Casebeer II	Montgomery
66,246	Angela Wilson-Cunningham, *et al.*, Appellees, v. Patricia A. Meyer, *et al.*, Appellees.	Craig E. Collins Robert K. Scovel Sheryl Bussell	Montgomery
	Summary Calendar—No Oral Argument		
66,155	State of Kansas, Appellee, v. Randall Joe Blevins, Appellant.	County Attorney Attorney General Jessica R. Kunen	Montgomery
66,000	State of Kansas, Appellee, v. Erasmo Ybarra, Appellant.	County Attorney Attorney General Jessica R. Kunen	Sherman

Kansas Court of Appeals
Court of Appeals Courtroom, 2nd Floor, Kansas Judicial Center
Topeka, Kansas
Before Pierron, P.J.; Larson and Lewis, JJ.

Wednesday, September 18, 1991
9:30 a.m.

Case No.	Case Name	Attorneys	County
66,381	Gerald H. Wietharn, Appellant, v. Safeway Stores, Inc., *et al.*, Appellees.	Kathryn D. Myers John J. Bryan Rex Henoch John D. Jurcyk	Shawnee
65,974	State of Kansas, Appellee, v. Phillip Turner, Appellant.	District Attorney Attorney General Rebecca Woodman	Douglas
65,979	Beverly Dalton, Appellant, v. State Farm Mutual Insurance, Appellee.	Steven M. Dickson Kevin L. Diehl	Shawnee
	Summary Calendar—No Oral Argument		
65,998	State of Kansas, Appellee, v. Tyrone L. Hutcherson, Appellant.	Gene M. Olander Attorney General Jessica R. Kunen	Shawnee

(continued)

65,894	Ronald Joel Pruitt, Appellant, v. State of Kansas, Appellee.	Ronald Pruitt, *pro se* Attorney General County Attorney	Harvey

Kansas Court of Appeals
Court of Appeals Courtroom, 2nd Floor, Kansas Judicial Center
Topeka, Kansas
Before Pierron, P.J.; Rulon and Lewis, JJ.
Wednesday, September 18, 1991
1:30 p.m.

Case No.	Case Name	Attorneys	County
65,985	State of Kansas, Appellee, v. Robert F. Horn, Appellant.	County Attorney Attorney General Tom Jacquinot	Atchison
65,970	State of Kansas, Appellee, v. Sherman N. Jenkins, Appellant.	County Attorney Attorney General Rebecca Woodman	Atchison
65,806	State of Kansas, Appellee, v. Sherman N. Jenkins, Appellant.	County Attorney Attorney General Pat Lawless	Atchison
	Summary Calendar—No Oral Argument		
66,205	State of Kansas, Appellee, v. Stephen C. Jennings, Appellant.	County Attorney Attorney General Jessica R. Kunen	Atchison
66,107	State of Kansas, Appellee, v. Daniel R. Sowder, Appellant.	County Attorney Attorney General Jessica R. Kunen	Lincoln

Kansas Court of Appeals
Supreme Court Courtroom, 3rd Floor, Kansas Judicial Center
Topeka, Kansas
Before Gernon, P.J.; Brazil and Davis, JJ.
Tuesday, September 17, 1991
9:30 a.m.

Case No.	Case Name	Attorneys	County
65,980	Chester L. Norton, Appellant, v. State of Kansas, Appellee.	Joel W. Meinecke Attorney General District Attorney	Johnson
66,551	In the Matter of the Marriage of Cheryl J. Emerson and David N. Emerson.	Peter V. Ruddick Drew Frackowiak	Johnson
66,258	Jorge A. Perez, Appellant, v. IBP, Inc., Appellee.	Stanley R. Ausemus Michael Downing	Lyon
	Summary Calendar—No Oral Argument		
65,912	State of Kansas, Appellee, v. Albert Nolan Garrison, Jr., Appellant.	District Attorney Attorney General Jessica R. Kunen	Johnson

66,119	State of Kansas, Appellee, v. Julian F. Fuel, Appellant.	District Attorney Attorney General Jessica R. Kunen	Johnson

Kansas Court of Appeals
Supreme Court Courtroom, 3rd Floor, Kansas Judicial Center
Topeka, Kansas
Before Gernon, P.J.; Brazil and Elliott, JJ.

Tuesday, September 17, 1991

1:30 p.m.

Case No.	Case Name	Attorneys	County
65,508	In the Matter of the Marriage of Leeissa Shahrak and Ali Shahrak.	Bryan E. Nelson D. Tiday	Johnson
66,383	In the Matter of the Marriage of Beverly C. Stigge and John Fredrick Stigge.	Robert L. Feldt Paul L. Monty	Barton
66,421	State of Kansas, Appellee, v. William J. Colding, Appellant.	District Attorney Attorney General Deborah D. Cox	Wyandotte

Summary Calendar—No Oral Argument

65,668	State of Kansas, Appellee, v. Michael Pusha, Appellant.	Debra Byrd Wagner Attorney General Jessica R. Kunen	Sedgwick
65,683	State of Kansas, Appellee, v. Jesse W. Alexander, Appellant.	County Attorney Attorney General Richard L. Dickson	Sumner

Kansas Court of Appeals
Supreme Court Courtroom, 3rd Floor, Kansas Judicial Center
Topeka, Kansas
Before Gernon, P.J.; Davis and Elliott, JJ.

Wednesday, September 18, 1991

9:30 a.m.

Case No.	Case Name	Attorneys	County
65,687	Roger M. Smith, Appellant, v. State of Kansas, Appellee.	Diane F. Barger Attorney General County Attorney	Lyon
66,396	State of Kansas, Appellee, v. Nannetta Marcum, Appellant.	County Attorney Attorney General Eric A. Stahl	Geary
66,212	Herbert F. Guyett, Appellant, v. Smith & Loveless, *et al.*, Appellees.	Mark S. Gunnison Rex Henoch Wade Dorothy	Johnson

(continued)

Summary Calendar—No Oral Argument

65,248	State of Kansas, Appellee,	Debra Byrd Wagner Attorney General	Sedgwick
	v.		
	Glen Moler, Appellant.	Jessica R. Kunen	
66,109	State of Kansas, Appellee,	County Attorney Attorney General	Reno
	v.		
	Alphonso Q. Toney, Appellant.	Jessica R. Kunen	

Kansas Court of Appeals
Supreme Court Courtroom, 3rd Floor, Kansas Judicial Center
Topeka, Kansas
Before Brazil, P.J.; Davis and Elliott, JJ.

Wednesday, September 18, 1991
1:30 p.m.

Case No.	Case Name	Attorneys	County
66,247	Roberta G. Scritchfield, Appellant,	Wm. Scott Hesse	Riley
	v.		
	BG Engineering, Appellee.	John D. Conderman	
66,382	State of Kansas, Appellee,	County Attorney Attorney General	Ellis
	v.		
	Thomas E. Williams, Appellant.	Stanley Juhnke	
65,835	State of Kansas, Appellee,	County Attorney Attorney General	Reno
	v.		
	Melvin Charles Handy, Appellant.	Tom Jacquinot	

Summary Calendar—No Oral Argument

65,783	Randolph C. Cabral, Appellant,	Jessica R. Kunen	Reno
	v.		
	State of Kansas, Appellee.	Attorney General County Attorney	
66,156	State of Kansas, Appellee,	County Attorney Attorney General	Reno
	v.		
	Kevin Drum, Appellant.	Jessica R. Kunen	

Lewis C. Carter
Clerk of the Appellate Courts

Doc. No. 011066

State of Kansas

Consumer Credit Commissioner

Permanent Administrative Regulations

Article 6.—UNIFORM CONSUMER CREDIT CODE

75-6-26. Federal truth-in-lending act requirements. Each creditor who, in the ordinary course of business, regularly extends or offers to extend consumer credit shall disclose to the consumer the information required by title I of the consumer protection act, public law 90-321; 82 stat. 146, as amended and in effect on March 1, 1990, and by Regulation Z, 12 C.F.R., Part 226, as amended and in effect on September 19, 1990. (Authorized by and implementing K.S.A. 16a-6-117; effective, E-82-16, Aug. 12, 1981; amended, T-83-2, Jan. 7, 1982; amended, T-83-6, April 14, 1982; amended, T-84-10, May 25, 1983; amended, T-85-15, May 3, 1984; amended, T-86-12, May 1, 1985; amended, T-87-14, June 6, 1986; amended, T-88-15, July 1, 1987; amended, T-75-7-29-88, July 29, 1988; amended Sept. 19, 1988; amended June 11, 1990; amended, Oct. 28, 1991.)

William F. Caton
Consumer Credit Commissioner

Doc. No. 011067

State of Kansas

Social and Rehabilitation Services

Permanent Administrative Regulations

Article 2.—GENERAL

30-2-16. Permanency planning goals for title IV-E of the federal social security act. (a) The agency's permanency planning goal for the federal fiscal year commencing on October 1, 1991 shall be to have no more than 450 children who have been in foster care placements in excess of 24 consecutive months receive federal funding during the course of the year.

(b) The following steps shall be taken by the agency to achieve the above stated goal.

(1) A reasonable effort shall be made to make adoption assistance available on behalf of eligible children; and

(2) a case review shall be initiated and a plan shall be developed for each child in the custody of the agency. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-83-26, Sept. 22, 1982; effective May 1, 1983; amended, T-85-24, Sept. 18, 1984; amended May 1, 1985; amended, T-87-5, May 1, 1986; amended, T-87-29, Oct. 22, 1986; amended May 1, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 30, 1990; amended Oct. 1, 1990; amended Oct. 28, 1991.)

Article 4.—PUBLIC ASSISTANCE PROGRAM

30-4-63. KanWork program requirements. Each assigned recipient, unless exempted, shall be required to participate in one or more components of the KanWork program. Any exempt recipient may volunteer for participation in the KanWork program. The geographic areas in the state and the public assistance programs in which the KanWork requirements are to be enforced shall be designated by the secretary. The administration of the KanWork program shall be within the limits of appropriations. (a) Exemptions. The persons listed below shall be exempt from the KanWork requirements:

(1) Any person who is ill, when determined on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training;

(2) any person who is incapacitated, when verified that a physical or mental impairment, determined by a physician or a licensed or certified psychologist, by itself or in conjunction with age, prevents the individual from engaging in employment or training. When an individual claims exempt status due to incapacity, but medical verification is needed to establish the incapacity, the individual shall be regarded as temporarily exempt for a period not to exceed 30 days while the individual's status is being verified. If verification is not provided because of a legitimate delay in obtaining an examination by or a consultation with a medical practitioner, the temporary exemption period shall be extended for a period not to exceed 15 days. For GA, a statement from a vocational rehabilitation counselor may be used to determine incapacity;

(3) any person who is under age 16 or 60 years of age or older;

(4) any person who is needed in the home because another member of the household requires the individual's presence due to illness or incapacity and no other appropriate member of the household is available to provide the needed care;

(5) any parent or other relative who is personally providing care for a child under age three, except that a custodial parent shall not be exempt from the educational component if the parent is under age 20, does not possess a high school diploma or its equivalent, and is not otherwise exempt. Only one person or other relative in a case may be exempt for providing care for a child under age three. This exemption cannot be claimed if the other parent or caretaker relative in the home or the stepparent in the plan is exempt from the work program requirements for another reason and is available and capable of providing child care;

(6) any person who is employed full-time, unless the employment was obtained during current participation in the program. Employment is considered to be full-time when the person is employed 30 or more hours a week and is earning at least the federal minimum wage;

(7) any person age 16, 17 or 18 who attends full-time an elementary, secondary, vocational or technical school. Persons age 18 shall be reasonably expected to complete the program before attaining age 19. This

(continued)

exemption shall not apply to a person who attends full-time an elementary, secondary, vocational or technical school as a required KanWork activity;

(8) any woman who is three or more months pregnant;

(9) any person who resides in an area of the state where the work program is available, but in a location which is so remote that effective participation is precluded. The person's location shall be considered remote if a round trip of more than two hours by reasonably available public or private transportation, exclusive of time necessary to transport children to and from a child care facility, would be required for a normal work or training day. However, if normal round trip commuting time in the area is more than two hours, then the round trip commuting time shall not exceed the generally accepted community standards;

(10) any parent or other caretaker of a child when another adult relative in the plan is participating in the KanWork program and the youngest child in the plan is under the age of three. If all children in the plan are age three or older, both parents shall be required to participate in the KanWork program; and

(11) any person who is a full-time volunteer serving under the Volunteers In Service To America (VISTA) program.

(b) Participation requirements. Each assigned recipient shall enter into a written agreement with the agency for the purpose of participating in one or more components of an agency-approved, work-related program directed toward a plan of self-sufficiency. The components of the KanWork program may include, but are not limited to, the following:

(1) Job search. Each assigned recipient shall participate in job search activities which may include agency-approved job clubs, supervised and unsupervised job search activities, job referral and placement services, and employment counseling.

(2) Community work experience program (CWEP). Each assigned recipient shall participate in CWEP activities which may include the opportunity to regain work skills, learn new skills, test interest and skills on the job, gain a work history, and obtain a work reference.

(3) Education and training. Each assigned recipient shall participate in education and training activities which are aimed at facilitating a recipient's movement toward self-sufficiency and employment retention. Education and training activities include such elements as vocational training, adult basic education, literacy training, general educational development, and post-secondary education and training.

(4) Work supplementation. Each assigned recipient shall participate in a work supplementation program in which an employer receives a wage subsidy from money diverted from public assistance grants for employing program participants.

(c) Support services. Support services shall be provided to participants. Support services shall include, but are not limited to:

(1) Transportation expenses, as outlined in K.A.R. 30-4-120(a)(1);

(2) day care expenses, as outlined in K.A.R. 30-4-120(a)(2); and

(3) education and training expenses, as outlined in K.A.R. 30-4-120(a)(3);

(d) Transitional services. Transitional services shall be provided to each participant and members of the participant's assistance family group who lose eligibility for public assistance due to the participant's employment. Transitional services shall include, but are not limited to, child care and transportation, as outlined in K.A.R. 30-4-120(a)(4), and medical assistance, as outlined in K.A.R. 30-6-65(n).

(e) Penalty. When a person who is required to participate in the KanWork program fails without good cause to participate in the program or refuses without good cause to accept employment, or terminates employment or reduces earnings without good cause, the individual shall be ineligible for assistance. In ADC-UP and GA, the spouse of the individual or the other parent in the household shall also be ineligible unless the spouse or the other parent is a KanWork participant. In GA, a potential employment penalty, as set forth in K.A.R. 30-4-58(d), shall be considered in combination with any other KanWork penalty. The period of ineligibility shall be as follows:

(1) For the first such failure or refusal, until the failure or refusal ceases;

(2) for the second such failure or refusal, until the failure or refusal ceases, or three months, whichever is longer; and

(3) for any subsequent failure or refusal, until the failure or refusal ceases, or six months, whichever is longer.

(f) Good cause. The individual shall be determined to have good cause for failing to participate in the program, refusing to accept employment, terminating employment, or reducing earnings if the individual has presented verification that one of the criteria listed below has been met:

(1) The person is exempt from participation in the program;

(2) there was no bona fide offer of employment or training;

(3) the person was incapable of performing the work or training;

(4) the work or training was so dangerous or hazardous according to OSHA standards as to make the refusal or termination a reasonable one;

(5) the payment offered was less than the applicable minimum wage;

(6) child care or day care for any incapacitated individual living in the same home is necessary for an individual to participate or continue participation in the program or accept employment and such care is not available and the agency fails to provide such care;

(7) the employment would result in the family of the participant experiencing a net loss of cash income;

(8) the assignment for training was not within the scope of the agency-approved plan;

(9) the total daily commuting time to and from home to the work or training site to which the individual is assigned exceeds two hours, not including the trans-

porting of a child to and from a child care facility. If a longer commuting distance is generally accepted in the community, the round trip commuting time shall not exceed the generally accepted community standards; or

(10) the person is the parent or other relative personally providing care for a child under age six and the employment requires the person to work more than 20 hours per week. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, 39-7,103; effective, T-30-7-29-88, July 29, 1988; effective Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; revoked, T-30-7-2-90, July 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended, T-30-6-10-91, July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct 28, 1991.)

30-4-64. Work program requirements. Each assigned recipient, unless exempted, shall be required to participate in one or more components of the work program. Any exempt recipient may volunteer for participation in the program. The geographic areas in the state and the public assistance programs in which work requirements are to be enforced shall be designated by the secretary. The administration of the work programs shall be within the limits of appropriations. (a) Exemptions. The persons listed below shall be exempt from the work requirements:

(1) Any person who is ill, when determined on the basis of medical evidence or another sound basis that the illness or injury is serious enough to temporarily prevent entry into employment or training;

(2) any person who is incapacitated, when verified that a physical or mental impairment, determined by a physician or a licensed or certified psychologist, by itself or in conjunction with age, prevents the individual from engaging in employment or training. When an individual claims exempt status due to incapacity, but medical verification is needed to establish the incapacity, the individual shall be regarded as temporarily exempt for a period not to exceed 30 days while the individual's status is being verified. If verification is not provided because of a legitimate delay in obtaining an examination by or a consultation with a medical practitioner, the temporary exemption period shall be extended for a period not to exceed 15 days. For GA, a statement from a vocational rehabilitation counselor may be used to determine incapacity;

(3) any person who is under age 16 or 60 years of age or older;

(4) any person who is needed in the home because another member of the household requires the individual's presence due to illness or incapacity and no other appropriate member of the household is available to provide the needed care;

(5) any parent or other relative who is personally providing care for a child under age three, except that a custodial parent shall not be exempt from the educational component if the parent is under age 20, does not possess a high school diploma or its equivalent, and is not otherwise exempt. Only one person or other relative in a case may be exempt for providing care for a child under age three. This exemption cannot be claimed if the other parent or caretaker relative in the home or the stepparent in the plan is exempt from the work program requirements for another reason and is available and capable of providing child care;

(6) any person who is employed full-time, unless the employment was obtained during current participation in the program. Employment is considered to be full-time when the person is employed 30 or more hours a week and is earning at least the federal minimum wage;

(7) any person age 16, 17 or 18 who attends full-time an elementary, secondary, vocational or technical school. Persons age 18 shall be reasonably expected to complete the program before attaining age 19. This exemption shall not apply to a person who attends full-time an elementary, secondary, vocational or technical school as a required work program activity;

(8) any woman who is three or more months pregnant;

(9) any person who resides in an area of the state where the work program is available, but in a location which is so remote that effective participation is precluded. The person's location shall be considered remote if a round trip of more than two hours by reasonably available public or private transportation, exclusive of time necessary to transport children to and from a child care facility, would be required for a normal work or training day. However, if normal round trip commuting time in the area is more than two hours, then the round trip commuting time shall not exceed the generally accepted community standards;

(10) any parent or other caretaker of a child when another adult relative in the plan is participating in the work program and the youngest child in the plan is under the age of three. If all children in the plan are age three or older, both parents shall be required to participate in the work program; and

(11) any person who is a full-time volunteer serving under the Volunteers In Service To America (VISTA) program.

(b) Participation requirements. Each assigned recipient shall participate in one or more components of an agency-approved, work-related program directed toward a plan of self-sufficiency. The components of the work program may include, but are not limited to, the following:

(1) Job search. Each assigned recipient shall participate in job search activities which may include agency-approved job clubs, supervised and unsupervised job search activities, job referral and placement services, and employment counseling.

(2) Community work experience program (CWEP). Each assigned recipient shall participate in CWEP activities which may include the opportunity to regain work skills, learn new skills, test interest and skills on the job, gain a work history, and obtain a work reference.

(3) Education and training. Each assigned recipient shall participate in education and training activities

(continued)

which are aimed at facilitating a recipient's movement toward self-sufficiency and employment retention. Education and training activities include such elements as vocational training, adult basic education, literacy training, general educational development, and post-secondary education and training.

(c) Support services. Support services shall be provided to participants. Support services shall include, but are not limited to:

(1) Transportation expenses, as outlined in K.A.R. 30-4-120(a)(1);

(2) day care expenses, as outlined in K.A.R. 30-4-120(a)(2); and

(3) education and training expenses, as outlined in K.A.R. 30-4-120(a)(3).

(d) Transitional services. Transitional services shall be provided to each participant and to members of the participant's assistance family group who lose eligibility for ADC or APW due to the participant's employment. Transitional services shall include, but are not limited to, child care, as outlined in K.A.R. 30-4-120(a)(4), and medical assistance, as outlined in K.A.R. 30-6-65(n).

(e) Penalty. When a person who is required to participate in the work program fails without good cause to participate in the program, refuses without good cause to accept employment, or terminates employment or reduces earnings without good cause, the individual shall be ineligible for assistance. In ADC-UP and GA, the spouse of the individual or the other parent in the household shall also be ineligible unless the spouse or the other parent is a work program participant. In GA, a potential employment penalty, as set forth in K.A.R. 30-4-58(d), shall be considered in combination with any work program penalty. The period of ineligibility shall be as follows:

(1) For the first such failure or refusal, until the failure or refusal ceases;

(2) for the second such failure or refusal, until the failure or refusal ceases, or three months, whichever is longer; and

(3) for any subsequent failure or refusal, until the failure or refusal ceases, or six months, whichever is longer.

(f) Good cause. The good cause criteria set forth in K.A.R. 30-4-63(f) shall be used in determining good cause for the work program requirements. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, 39-7,103; effective Oct. 1, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; revoked, T-30-7-2-90, July 2, 1990; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended Jan. 7, 1991; amended, T-30-6-10-91, July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-4-90. Eligibility factors specific to the GA-unrestricted (GAU) program. (a) Each applicant or recipient shall meet the applicable general eligibility requirements of K.A.R. 30-4-50, and the specific eligibility requirements set forth below, in order to be eligible for GAU.

(1) Each applicant or recipient, and the members of the assistance family group for whom the applicant or recipient is legally responsible, shall be ineligible for GAU if the applicant or recipient:

(A) Is eligible for a federal program; or

(B) has been rendered ineligible for a federal program due to a voluntary action on the part of the applicant or recipient.

(2) Each applicant or recipient and the members of the assistance family for whom the applicant or recipient is legally responsible shall be ineligible for GAU if the applicant or recipient:

(A) Refuses to accept a referral to the vocational rehabilitation program;

(B) is eligible for vocational rehabilitation program services and has refused services; or

(C) has been rendered ineligible for vocational rehabilitation program services due to a voluntary action on the part of the applicant or recipient.

(3) Each applicant or recipient, and the members of the assistance family for whom the applicant or recipient is legally responsible, shall be ineligible for GAU if the applicant or recipient:

(A) Is eligible for vocational rehabilitation program benefits related to maintenance; or

(B) has been rendered ineligible for these benefits due to a voluntary action on the part of the applicant or recipient.

(4) Each applicant or recipient and all persons for whom the applicant or recipient is legally responsible, if living together, shall be within at least one of the following categories to be eligible for GAU:

(A) Parents and their minor children who are living together provided the parents are not voluntarily unavailable for employment. A person shall not be considered voluntarily unavailable for employment if the person is attending high school full-time or is participating in an agency-approved work related activity. Assistance under this provision may not be denied solely because a person is participating in post-secondary education or training activities during other than normal working hours. Assistance under this provision shall also be granted to non-ADC children who are living with a guardian or a personal representative who is not within the degree of relationship for ADC;

(B) a person who has been medically-determined to be physically incapacitated as set forth in K.A.R. 30-4-63(a)(2), except that the condition must only constitute a substantial handicap to gainful employment;

(C) a person who has been medically or psychologically determined to be mentally retarded;

(D) a person who has been medically or psychologically determined to be mentally ill to the extent that the condition constitutes a substantial handicap to gainful employment. A statement from a vocational rehabilitation counselor may be used to determine eligibility under this provision;

(E) a person whose presence is required at home because of a verified, medically determined condition of another member of the home whose condition does not permit self-care, and when the care is not available from another person in the home;

(F) a person who is participating in vocational rehabilitation program training;

(G) a person who is residing in a licensed or certified alcohol and drug abuse facility;

(H) a person who is age 55 or older; or

(I) a woman who is pregnant and not eligible for APW. If married, her husband shall also be included in the same assistance plan if they are living together. Neither the pregnant woman nor her husband shall be voluntarily unavailable for employment;

(J) a parent or parents of a child who has been removed from the home and placed in foster care, provided that there is an agency-approved plan to return the child to the home;

(K) a full-time high school student who is under 21 years of age; or

(L) a child in a family group who is not otherwise eligible for assistance as a result of an established period of ineligibility resulting from the provisions of K.A.R. 30-4-58(d), 30-4-63(e), 30-4-64(d), or 30-4-110(c)(8) provided there is an approved social service plan substantiating that the child is facing imminent removal from the home and placement into a foster care arrangement if assistance is not reinstated. Assistance shall be provided in accordance with the social service plan which shall not exceed the budget deficit for the family group.

(5) The needs of the applicant or recipient and all persons for whom the applicant or recipient is legally responsible shall be included in the same assistance plan, if living together, except for persons who are not otherwise eligible. The needs of certain persons in the family group who are not otherwise eligible shall be excluded in determining eligibility for GAU. However, the resources of certain persons in the family group shall, unless the resources are specifically exempt, be included in determining eligibility for GAU. Such persons include:

(A) SSI recipients;

(B) persons who are ineligible due to the receipt of lump sum income;

(C) persons who are ineligible due to a sanction;

(D) minor parents whose needs are met through foster care payments; and

(E) aliens who are ineligible because of the citizenship and alienage requirements or sponsorship provisions.

(b) A presumptive eligibility determination shall be made for persons who are being released from a medicaid-approved psychiatric hospital or from the extended care unit at the Kansas state penitentiary in accordance with an approved discharge plan. Minimally, the presumptive determination shall be based on available information concerning the person's income and resources. The general eligibility requirements of K.A.R. 30-4-50 may be waived until a formal eligibility determination is completed. Assistance provided shall equal 100% of the applicable GAU budgetary standards and the provision of subsection (a)(1) of K.A.R. 30-4-140 shall be waived. Assistance under this provision shall not exceed the month of discharge and the two following months. Assistance under this provision may be extended by the department beyond the three-month limitation for good cause.

(c) Each applicant or recipient who refuses to authorize the department to file for and claim reimbursement from the social security administration for the amount of GAU provided the individual pending a determination of eligibility for the supplemental security income program shall be ineligible for GAU. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-34, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991.)

30-4-101. Standards for persons in own home, other family home, specialized living, commercial board and room, or commercial room-only living arrangements. A monetary standard addresses the costs of day-to-day expenses and certain special expenditures. (a) Basic standard. The basic standards shall be those set forth below. The basic standards include $17.00 per person as an energy supplement.

PERSONS IN PLAN			
1	2	3	4
$130.00	$212.00	$287.00	$353.00

For each additional person, add $59.00.

(b) Shelter standard. A standard has been established for shelter based on location in the state. The county shelter standards shall be those set forth below.

Standard.	Group I $92.00		
	Allen	Gove	Norton
	Anderson	Graham	Osborne
	Atchison	Grant	Ottawa
	Barber	Greeley	Phillips
	Barton	Greenwood	Pottawatomie
	Bourbon	Hamilton	Pratt
	Brown	Harper	Rawlins
	Chase	Haskell	Republic
	Chautauqua	Hodgeman	Rooks
	Cherokee	Jackson	Rush
	Cheyenne	Jewell	Russell
	Clark	Kearny	Saline
	Clay	Kingman	Scott
	Cloud	Labette	Sheridan
	Coffey	Lane	Smith
	Comanche	Lincoln	Stafford
	Cowley	Linn	Stanton
	Crawford	Logan	Stevens
	Decatur	Lyon	Sumner
	Dickinson	Marion	Thomas
	Doniphan	Marshall	Trego
	Edwards	Meade	Wabaunsee
	Elk	Mitchell	Wallace
	Ellis	Montgomery	Washington
	Ellsworth	Morris	Wichita
	Finney	Nemaha	Wilson
	Ford	Neosho	Woodson
	Geary	Ness	

(continued)

	Group II	Group III	Group IV
Standard.	$97.00	$109.00	$135.00
	Franklin	Butler	Douglas
	Gray	Jefferson	Harvey
	Kiowa	Leavenworth	Johnson
	Morton	McPherson	
	Pawnee	Miami	
	Seward	Osage	
	Sherman	Reno	
		Rice	
		Riley	
		Sedgwick	
		Shawnee	
		Wyandotte	

The effective date of this regulation shall be October 28, 1991. (Authorized by K.S.A. 1990 Supp. 39-708c; implementing K.S.A. 1990 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended, T-83-17, July 1, 1982; amended May 1, 1983; amended, T-85-19, July 1, 1984; amended May 1, 1985; amended, T-86-19, July 1, 1985; amended, T-86-42, Jan. 1, 1986; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-88-2, Feb. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended, T-88-14, July 1, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-5-1-90, May 1, 1990; amended, T-30-8-28-90, Aug. 30, 1990; amended, T-30-12-28-90, Dec. 28, 1990; amended April 1, 1991; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991.)

Article 5.—PROVIDER PARTICIPATION, SCOPE OF SERVICES, AND REIMBURSEMENTS FOR THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

30-5-58. Definitions. (a) The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise:

(1) "Accept medicare assignment" means accept the medicare allowed payment rate as payment in full for services provided to a recipient.

(2) "Accrual basis accounting" means reporting revenue in the period when it is earned, regardless of when it is collected, and reporting expenses in the period in which they are incurred, regardless of when they are paid.

(3) "Acquisition cost" means the allowable reimbursement price determined by the Kansas department of social and rehabilitation services for each covered drug, supply or device in accordance with federal regulations.

(4) "Activities of daily living" means basic activities necessary for daily self care.

(5) "Admission" means the condition of entry into a hospital for the purpose of receiving inpatient medical treatment.

(6) "Ambulance" means a state-licensed vehicle equipped for emergency transportation of injured or sick recipients to facilities where medical services are rendered.

(7) "Arm's length transaction" means a transaction between unrelated parties.

(8) "Border cities" mean those communities outside of the state of Kansas but within a 50-mile range of the state border.

(9) "Case conference" means a scheduled face-to-face meeting involving two or more persons to discuss problems associated with the treatment of the facility's patient or patients. Persons involved in the case conference may include treatment staff, collaterals or other department representatives of the client or clients.

(10) "Capitation reimbursement" means a reimbursement methodology establishing payment rates, per program recipient or eligible individual, for a designated group of services.

(11) "Change of ownership" means:

(A) A change that involves an arm's length transaction between unrelated parties; and

(B)(i) The dissolution or creation of a partnership when no member of the dissolved partnership or the new partnership retains ownership interest from the previous ownership affiliation;

(ii) a transfer of title and property to another party if the transfer is an arm's length transaction, and if the property is owned by a sole proprietor;

(iii) the change or creation of a new lessee, acting as a provider of pharmacy services; or

(iv) the consolidation of two or more corporations that creates a new corporate entity. However, the transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with a participating provider corporation surviving shall not constitute a change of ownership.

(12) "Common control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(13) "Common ownership" means that an individual or individuals possess significant ownership or equity in the provider and the facility or organization serving the provider.

(14) "Comparable outpatient service" means a service that is provided in a hospital that is comparable to a service provided in a physician's office or ambulatory surgical center.

(15) "Comparison per diem rate" means the per diem rate as adjusted by deducting the teaching cost for approved intern, resident and nursing programs divided by the total hospital inpatient days in the hospital fiscal year ending in 1981.

(16) "Concurrent care" means services rendered simultanously by two or more eligible providers.

(17) "Consultation" means an evaluation which requires another examination by a provider of the same profession, a study of records, and a discussion of the case with the physician primarily responsible for the patient's care.

(18) "Contract loss" means the excess of contract cost over contract income.

(19) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(20) "Cost outlier" means a general hospital inpatient stay with an estimated cost which exceeds the cost outlier limit established for the respective diagnosis related group.

(21) "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established according to a methodology specified by the secretary for each diagnosis related group.

(22) "Cost-related reimbursement" means reimbursement based on analysis and consideration of the historical operating costs required to provide specified services.

(23) "Covered service" means a medical service for which reimbursement will be made by the medicaid/medikan program. The department may limit coverage on the basis of prior authorization.

(24) "Day outlier" means a general hospital inpatient length of stay which exceeds the day outlier limit established for the respective diagnosis related group.

(25) "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the secretary for each diagnosis related group.

(26) "Diagnosis related group (DRG)" means the classification system which arranges medical diagnoses into mutally exclusive groups.

(27) "Diagnosis related group (DRG) adjustment percent" means a percentage assigned by the secretary to a diagnosis related group for purposes of computing reimbursement.

(28) "Diagnosis related group (DRG) daily rate" means the dollar amount assigned by the secretary to a diagnosis related group for purposes of computing reimbursement when a rate per day is required.

(29) "Diagnosis related group (DRG) reimbursement system" means a reimbursement system in the Kansas medicaid/medikan program for general hospital inpatient services which uses diagnosis related groups for determining reimbursement on a prospective basis.

(30) "Diagnosis related group (DRG) weight" means the numeric value assigned to a diagnosis related group for purposes of computing reimbursement.

(31) "Discharge" means the condition of release from a hospital. A discharge shall occur when the recipient leaves the hospital or dies. A transfer to another unit within a hospital, except to a swing bed, and a transfer to another general or special hospital shall not be a discharge.

(32) "Discharging hospital" means, in instances of the transfer of a recipient, the hospital which discharges the recipient admitted from the last transferring hospital.

(33) "Disproportionate share hospital" means a hospital that has:

(A) A medicaid/medikan inpatient utilization rate of at least one standard deviation above the mean medicaid/medikan inpatient utilization rate for hospitals within the state borders of Kansas which are receiving medicaid/medikan payments or a hospital with a low-income utilization rate exceeding 25%; and

(B) at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to medicaid/medikan eligible individuals. In a hospital located in a rural area, the obstetrician may be any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The only exceptions to this shall be:

(i) A hospital with inpatients who are predominantly under 18 years of age; or

(ii) a hospital which did not offer non-emergency obstetric services as of December 21, 1987.

(34) "Drug, supply or device" means:

(A) Articles recognized in the official United States pharmacopoeia, or other such official compendiums of the United States, or official national formulary, or any supplement of any of them;

(B) articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in human beings;

(C) articles intended to affect the structure or any function of the bodies of human beings; and

(D) articles intended for use as components of any articles specified in clause (A), (B) or (C) of this paragraph.

(35) "Durable medical equipment (DME)" means equipment which will:

(A) Withstand repeated use;

(B) not generally be useful to a person in the absence of an illness or injury;

(C) be primarily and customarily used to serve a medical purpose;

(D) be appropriate for use in the home; and

(E) be rented or purchased as determined by designees of the secretary.

(36) "Election period" means the period of time for the receipt of hospice care, beginning with the first day of hospice care as provided in the election statement and continuing through any subsequent days excluding any days of hospice care earlier than the date the election statement is signed.

(37) "Election statement" means the revokable statement signed by a recipient which is filed with a particular hospice and which consists of:

(A) Identification of the hospice selected to provide care;

(B) acknowledgement that the recipient has been given a full explanation of hospice care;

(C) acknowledgement by the recipient that other medicaid services are waived;

(D) effective date of the election period; and

(E) the recipient's signature or the signature of the recipient's legal representative.

(38) "Emergency services" means those services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably by expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(39) "Estimated cost" means the cost of general hospital inpatient services provided to a recipient which are computed using a methodology set out in the Kansas medicaid state plan.

(40) "Formulary" means a listing of drugs, supplies or devices.

(continued)

(41) "Free-standing inpatient psychiatric facility" means an inpatient psychiatric facility licensed to provide services only to the mentally ill.

(42) "General hospital" means an establishment with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients who have a variety of medical conditions.

(43) "General hospital group" means the category to which a general hospital is assigned for purposes of computing reimbursement.

(44) "General hospital inpatient beds" mean the number of beds as reported by the general hospital on the hospital and hospital health care complex cost report form excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form, the number of beds shall be obtained from the provider application for participation in the Kansas medicaid/medikan program form.

(45) "Group reimbursement rate" means the dollar value assigned by the secretary to each general hospital group for a diagnosis related group weight of one.

(46) "Health maintenance organization" means an organization of providers of designated medical services which makes available and provides these medical services to eligible enrolled individuals for a fixed periodic payment which is determined in advance. Referral to outside specialists is limited.

(47) "Historical cost" means actual allowable costs incurred for a specified period of time.

(48) "Home health aide service" means the direct care provided by a person with minimum training, and who is under the supervision of a registered nurse employed by a home health agency, to recipients who are unable to care for themselves or who need assistance in accomplishing the activities of daily living.

(49) "Hospice" means a public agency or private organization, or a subdivision of either, that primarily engages in providing care to terminally ill individuals, which meets the medicare conditions of participation for hospices, and which has enrolled to provide hospice services pursuant to K.A.R. 30-5-59.

(50) "Hospital located in a rural area" means a facility located in an area outside of a metropolitan statistical area as defined by the executive office of management and budget under the health care financing administration.

(51) "Independent laboratory" means a laboratory that performs laboratory tests that are ordered by a physician, and that is in a location other than the physician's office or a hospital.

(52) "Ineligible provider" means a provider who is not enrolled in the medicaid/medikan program because of reasons set forth in K.A.R. 30-5-60, or because of commission of civil or criminal fraud in another state or another program.

(53) "Interest expense" means the cost incurred for the use of borrowed funds on a loan made for a purpose related to patient care.

(54) "Kan Be Healthy program participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule in order to ascertain physical and mental defects and to provide treatment which corrects or ameliorates defects and chronic conditions found.

(55) "Kan Be Healthy dental-only participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule in order to ascertain dental defects and to provide treatment which corrects or ameliorates dental defects and chronic dental conditions found.

(56) "Kan Be Healthy vision-only participant" means an individual under the age of 21 who is eligible for medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule in order to ascertain vision defects and to provide treatment which corrects or ameliorates vision defects and chronic vision conditions found.

(57) "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

(58) "Lock-in" means the restriction of a recipient's access to medical services because of abuse through limitation of the use of the medical identification card to designated medical providers.

(59) "Low-income utilization rate for hospitals" means the rate which is defined in accordance with the omnibus budget reconciliation act, public law 100-203, Section 4112, effective July 1, 1988, which is adopted by reference.

(60) "Managerial capacity" means an individual, including a general manager, business manager, administrator, or director, who exercises operational or managerial control over the provider, or who directly or indirectly conducts the day to day operations of the provider.

(61) "Maternity center" means a facility licensed as a maternity hospital which provides delivery services for normal uncomplicated pregnancies.

(62) "Medicaid home- and community-based services for persons with head injury trauma (HCBS/HI)" means services provided in accordance with a federally-approved waiver to the Kansas medicaid state plan that are designed to be alternatives to services in head injury rehabilitation facilities to individuals with external, traumatic head injuries.

(63) "Medicaid home- and community-based services for persons with mental retardation or other developmental disabilities (HCBS/MRDD)" means services provided in accordance with a federally-approved waiver to the Kansas medicaid state plan that are designed to be alternatives to services otherwise provided in intermediate care faciliteis for the mentally retarded (ICF/MR) to individuals who have mental retardation or other developmental disabilities.

(64) "Medicaid/medikan hospital inpatient utilization rate" means the total number of medicaid/medikan paid inpatient days in a cost reporting period, divided

by the total number of the hospital's inpatient days in the same period.

(65) "Medical necessity" means a decision by a medical practitioner that a therapy, treatment, drug, item or service prescribed or provided is essential to treat or diagnose a specific physical or psychiatric condition.

(66) "Medical necessity in psychiatric situations" means that there is medical documentation which indicates that the person could be harmful to himself or herself or others if not under psychiatric treatment, or the person is disoriented in time, place or person.

(67) "Medical supplies" means supplies not generally useful to a person in the absence of illness or injury which are prescribed by a physician and used in the home and certain institutional settings.

(68) "Mental retardation" means significatly subaverage intelletual functioning which:

(A) Is manifested before age 22; and

(B) is evidenced by:

(i) A score of 70 or below on any standardized measure of intelligence; and

(ii) concurrently existing deficits in adaptive behavior.

(69) "Metropolitan statistical area (MSA)" means a geographic area designated as such by the United States executive office of management and budget as set out in the Federal Register, Vol. 53, No. 244, December 20, 1988, which is adopted by reference.

(70) "Necessary interest" means interest expense incurred on a loan made to satisfy a financial need of the facility. Loans which result in excess funds or investments shall not be considered necessary.

(71) "Net cost" means the cost of approved educational activities less any reimbursements from grants, tuition, and specific donations.

(72) "Non-covered services" mean services for which medicaid/medikan will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

(73) "Occupational therapy" means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall be:

(A) Rehabilitative and restorative in nature;

(B) provided following physical debilitation due to acute physical trauma or physical illness; and

(C) prescribed by the attending physician.

(74) "Orthotics and prosthetics" mean devices which are:

(A) Reasonable and necessary for treatment of an illness or injury;

(B) prescribed by a physician;

(C) necessary to replace or improve functioning of a body part; and

(D) provided by a trained orthotist or prosthetist.

(75) "Other developmental disabilities" means a condition or illness which:

(A) Is manifested before age 22;

(B) may reasonably be expected to continue indefinitely;

(C) results in substantial limitations in any three or more of the following areas of life functioning:

(i) Self-care;

(ii) understanding and the use of language;

(iii) learning and adapting;

(iv) mobility;

(v) self-direction in setting goals and undertaking activities to accomplish those goals;

(vi) living independently; or

(vii) economic self-sufficiency; and

(D) reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of extended or lifelong duration and are individually planned and coordinated.

(76) "Out-of-state provider" means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. Nursing facilities, intermediate care facilities, community mental health centers, partial hospitalization service providers, and alcohol and drug program providers shall be considered out-of-state providers if they are physically located beyond the border of Kansas.

(77) "Outpatient treatment" means services provided by the outpatient department of a hospital, a facility that is not under the administration of the hospital, or a physician's office.

(78) "Over-the-counter" means any item available for purchase without a prescription order.

(79) "Owner" means a sole proprietor, member of a partnership or a corporate stockholder with 5% or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly-held corporations.

(80) "Partial hospitalization program" means an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and daily living skills treatment modalities based upon a treatment plan.

(81) "Participating provider" means any individual or entity that has in effect an agreement with the Kansas department of social and rehabilitation services to furnish medicaid services.

(82) "Pharmacy" means the premises, laboratory, area or other place:

(A) Where drugs are offered for sale, the profession of pharmacy is practiced and prescriptions are compounded and dispensed;

(B) which has displayed upon it or within it the words "pharmacist," "pharmaceutical chemist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "drug sundries," or any combinations of these words or words of similar import; and

(C) where the characteristic symbols of pharmacy or the characteristic prescription sign "Rx" are exhibited. The term "premises" as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

(83) "Pharmacist" means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

(continued)

(84) "Physical therapy" means treatment which:

(A) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;

(B) is rehabilitative and restorative in nature;

(C) is provided following physical debilitation due to acute physical trauma or physical illness; and

(D) is prescribed by the attending physician.

(85) "Physician extender" means a person registered as a physician's assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided and who is working under supervision as required by law or administrative regulation.

(86) "Plan of care" means a document which states the need for care, the estimated length of program, the prescribed treatment, modalities, and methodology to be used, and the expected results.

(87) "Practitioner" means any person licensed to practice medicine and surgery, dentistry or podiatry, or any other person licensed, registered or otherwise authorized by law to administer, prescribe and use prescription-only drugs in the course of professional practice.

(88) "Prescribed" means the issuance of a prescription order by a practitioner.

(89) "Prescription" means, according to the context, either a prescription order or a prescription medication.

(90) "Prescription medication" means any drug, supply or device, including label and container according to context, which is dispensed pursuant to a prescription order.

(91) "Prescription-only" means an item available for purchase only with a prescription order.

(92) "Primary care network" means a service delivery control system in which physicians, in independent or group practices, local health departments, or clinics act as primary care providers and are responsible for initiating or approving specified medical services for participating recipients.

(93) "Primary diagnosis" means the most significant diagnosis related to the services rendered.

(94) "Prior authorization" means the approval of a request to provide a specific service before the provision of the service.

(95) "Professional fee" means the reimbursement rate assigned to each individual pharmacy provider for provision of pharmacy services.

(96) "Program" means the Kansas medicaid/medikan program.

(97) "Proper interest" means interest incurred at a rate not in excess of what a prudent borrower would have had to pay under market conditions existing at the time the loan was made.

(98) "Prospective, reasonable cost-related reimbursement" means present and future reimbursement, based on analysis and consideration of the historical cost that is related to patient care, in the operation of facilities and programs.

(99) "Qualified medicare beneficiary (QMB)" means an individual who is entitled to medicare hospital insurance benefits under part A of medicare, whose income does not exceed a specified percent of the official poverty level as defined by the United States executive office of management and budget, and whose resources do not exceed twice the supplemental security income resource limit.

(100) "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another DRG hospital.

(101) "Related parties" means that one party of a transaction has the ability to significantly influence another party in the transaction to the extent that either of their own separate interests may not be fully pursued. Related parties include those related by family, by business or financial association, or by common ownership or control.

(102) "Related to the community mental health center" means that the agency or facility furnishing services to the community mental health center is directly associated or affiliated with the community mental health center by formal agreement, or that it governs the community mental health center, or is governed by the community mental health center.

(103) "Residence for the payment of hospice services" means a hospice recipient's home or the nursing facility in which a hospice recipient is residing.

(104) "Revocation statement" means the statement signed by the recipient which revokes the election of hospice service.

(105) "Special hospital" means an establishment with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients who have specified medical conditions, or which are located within the state of Kansas and at least 10 percent of the historic cost of the hospital is incurred for teaching physicians or nurses.

(106) "Speech therapy" means treatment provided by a speech pathologist who has a certificate of clinical competence from the American speech and hearing association. The treatment shall be rehabilitative and restorative in nature, shall be provided following physical debilitation due to acute physical trauma or physicial illness, and shall be prescribed by the attending physician.

(107) "Standard diagnosis related group (DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

(108) "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

(109) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital, skilled nursing facility, or intermediate care facility bed, with reimbursement based on the specific type of care provided.

(110) "Targeted case management services" means those services to assist medicaid recipients in gaining access to medically necessary care, and which are provided by a case manager with credentials specified by the department of social and rehabilitation services.

(111) "Technology-assisted child" means a chroni-

cally ill or medically fragile child younger than 16 years whose illness or disability, in the absence of home care services, would require admission to or prolonged stay in a hospital. The technology-assisted child needs both a medical device to compensate for the loss of a vital body function and substantial continuous care by a nurse or other caretaker under the supervision of a nurse in order to avert death or further disability. A technology-assisted child shall require substantial and ongoing care by a nurse, and be dependent at least part of each day on mechanical ventilators for survival, require prolonged intravenous administration of nutritional substances or drugs, or require other medical devices to compensate for the loss of a vital body function.

(112) "Terminally ill" means the medical condition of an individual whose life expectancy is six months or less as determined by a physician.

(113) "Timely filing" means the receipt by the Kansas department of social and rehabilitation services or its fiscal agent of a claim for payment from a provider for services provided to a medicaid program recipient which is no later than six months after the date the claimed services were provided.

(114) "Transfer" means the movement of an individual receiving general hospital inpatient services from one hospital to another hospital for additional related inpatient care after admission to the previous hospital or hospitals.

(115) "Transferring hospital" means the hospital which transfers a recipient to another hospital. There may be more than one transferring hospital for the same recipient until discharge.

(116) "Traumatic head injury" means non-degenerative, structural brain damage resulting in residual deficits and disability which have been acquired by external physical injury.

(117) "Uncollectable overpayment to an out-of-business provider" means:

(A) Any amount which is due from a provider of medical services who has ceased all practice or operations for any medical services as an individual, a partnership or a corporate identity, and who has no assets capable of being applied to any extent toward a medicaid overpayment; or

(B) any amount due which is less than its collection and processing costs.

(118) "Urgent" means situations which require immediate admission, but not through the emergency room.

(b) The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1988; amended, T-30-7-29-88, July 29, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended Jan. 2, 1990; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended Aug. 1, 1990; amended Jan. 7, 1991; amended, T-30-3-1-91, March 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-5-70. Payment of medical expenses for eligible recipients. (a) Payment for covered services shall be made only to those providers participating in the program pursuant to K.A.R. 30-5-59. The only exception to this provision shall be that payment for services provided to foster care or adoption support recipients may be made to providers not participating in the program.

(b) Program recipients shall be eligible for the payment of specific medical expenses as follows:

(1) Payment of medicare (title XVIII) premiums and deductibles and co-insurance amounts for services covered in the medicaid program. Recipients who are ineligible for program coverage because they have a spenddown shall be eligible for the payment of the medicare (title XVIII) premium expense. For cash recipients, including SSI recipients, age 65 or older, payment of the medicare (title XVIII) premium shall begin with the month of approval for medicaid, excluding any months of prior eligibility. For recipients under age 65 who are eligible for medicare after receiving retirement and survivor's disability insurance for 24 consecutive months, payment of the medicare (title XVIII) premium shall begin with the 25th month. For all other recipients, payment of the medicare (title XVIII) premium shall begin with the second month following the month of approval for medicaid, excluding any months of prior eligibility;

(2) payment of premiums of health maintenance organizations which are approved by the agency;

(3) payment of other allowable medical expenses incurred in the current eligibility base period in excess of any co-pay or spenddown requirements;

(4) payment for services rendered to a person who is mandated to receive inpatient treatment for tuberculosis and who is not otherwise eligible for participation in the program. Coverage shall be limited to services related to the treatment for tuberculosis;

(5) services in excess of medicaid/medikan program limitations for foster care and adoption support recipients, when approved by the agency; and

(6) payment for covered medical services provided to an individual participating in the KanWork program. A monthly cost sharing amount for medical services shall be paid by each individual participating in the KanWork program when required.

(c) The scope of services to be provided recipients and the payment for those services shall be as set forth in articles 5 and 10 of this chapter, subject to the following limitations.

(1) Payment for a particular medical expense shall be denied if it is determined that:

(A) The recipient failed to utilize medical care available through other community resources, including public institutions, veterans administration benefits, and those laboratory services that are available at no charge through the state department of health and environment;

(B) a third party liability for the medical expense has been established and is available;

(C) the recipient fails to make a good faith effort to establish a third party liability for the medical expense

(continued)

or fails to cooperate with the agency in establishing the liability. Payment of a medical expense may be delayed pending the outcome of a determination concerning third party liability;

(D) the expense is not covered or is only partially covered by an insurance policy because of an insurance program limitation or exclusion;

(E) the recipient failed to notify the provider of services of the recipient's eligibility for the program;

(F) the service is cosmetic, pioneering, experimental, or a result of complications related to such procedures;

(G) the service is related to transplant procedures which are noncovered by the medicaid/medikan program;

(H) the service was provided by a provider not designated as a lock-in provider for any recipient who is locked into designated providers due to abuse or participation in a primary care network. This limitation shall not apply to emergency services or services not provided by the primary care network; or

(I) the service was provided by an unlicensed, unregistered or noncertified provider when licensure, registration or certification is a requirement to participate in the medicaid/medikan program.

(2) Payment for out-of-state services shall be limited to:

(A) Payment on behalf of recipients where medical services are normally provided by medical vendors that are located in the bordering state and within 50 miles of the state border, except for community mental health center services, alcohol and drug abuse services or partial hospitalization services;

(B) emergency services rendered outside the state;

(C) nonemergency services for which prior approval by the agency has been given. Authorization from the agency shall be obtained before making arrangements for the individual to obtain the out-of-state services;

(D) services provided by independent laboratories; and

(E) medical services provided to foster care recipients and medical services in excess of the limitations of the state of residence when approved by the Kansas department of social and rehabilitation services and within the scope of the adoption agreement for those for whom Kansas has initiated adoption support agreements.

(3) The scope of services for adult non-medicaid (non-title XIX) program recipients shall be limited as set forth in K.A.R. 30-5-150 through 30-5-172.

(4) Nursing facility and ICF/MR services shall not be covered for individuals who do not meet the financial provisions of K.A.R. 30-6-53(d).

(d) Payment for medical services shall be made when it has been determined and approved by the agency that an agency administrative error has been made. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; modified, L. 1982, ch. 469, May 1, 1982; amended, T-84-8, March 29, 1983; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-44, Jan. 1, 1987; amended May 1, 1987; amended, T-88-10, May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90 Jan. 2, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-5-78. Scope of and reimbursement for home- and community-based services for persons with head injury trauma. The scope of home- and community-based services for persons with head injury trauma shall consist of those services provided under the authority of the applicable federally-approved model waiver to the Kansas medicaid state plan. (a) Recipients of services provided pursuant to this waiver shall be capable of benefitting from rehabilitation by demonstrating improvement.

(b) Home- and community-based services shall be provided in accordance with a plan of care written by a licensed social worker or registered nurse and approved by the Kansas department of social and rehabilitation services. Prior to the development of any plan to provide services, the need for services shall be determined by an individualized assessment of the prospective recipient by a provider enrolled in the program.

(c) Mandatory services shall include:

(1) Case management services, up to a maximum of 116 hours per calendar year; and

(2) transitional living skills training, up to a maximum of seven four-hour days per week.

(d) Optional services may include one or more of the following:

(1) Rehabilitation therapies consisting of:

(A) Occupational therapy;

(B) physical therapy;

(C) speech-language therapy;

(D) cognitive therapy;

(E) behavioral therapy; or

(F) substance abuse therapy;

(2) medical alert rental and one-time installation costs;

(3) night support, up to a maximum of 12 hours but no less than eight hours per night;

(4) medical attendant care, which shall be reviewed by a registered nurse every 60 days;

(5) non-medical attendant care, with prior authorization by the case manager; or

(6) medical equipment and supplies not otherwise covered under the Kansas medicaid state plan, with prior authorization by the case manager.

(e) Reimbursement for home- and community-based services for persons with head injury trauma shall be based upon reasonable fees as related to customary charges, except that no fee shall be paid in excess of the range maximum. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-8-9-91, Aug. 30, 1991; effective Oct. 28, 1991.)

30-5-79. Scope of and reimbursement for home- and community-based services for persons with mental retardation or other developmental disabilities. The scope of home- and community-based services for

persons with mental retardation or other developmental disabilities shall consist of those services provided under the authority of the applicable federally-approved waiver to the Kansas medicaid state plan. (a) Prior to the development of any plan to provide services, the need for services shall be determined by an individualized assessment of the prospective recipient by a provider of community-based screening services.

(b) Home- and community-based services shall be provided in accordance with an individualized, written plan of care approved in writing by the Kansas department of social and rehabilitation services. Each annual review and amendment of this plan shall be approved in the same fashion. This plan shall:

(1) Be based on needs identified during the screening assessment;

(2) specify each service to be provided and why each service was selected, or how each service will address any specific need identified by the assessment;

(3) specify the frequency, and within what limits, each service shall be provided;

(4) specify what other support services are required and the plan for obtaining them;

(5) be prepared in consultation with the recipient and the recipient's guardian, if one has been appointed;

(6) be approved in writing by the recipient or the recipient's guardian, as appropriate; and

(7) be reviewed at least annually and updated as necessary.

(c) Reimbursement for home- and community-based services for persons with mental retardation or other developmental disabilities shall be based upon reasonable fees as related to customary charges, except that no fee shall be paid in excess of the range maximum. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 39-708c; effective, T-30-8-9-91, Aug. 30, 1991; effective Oct. 30, 1991.)

30-5-101. Scope of chiropractic services. Chiropractic services shall be covered for Kan Be Healthy program participants. (a) Up to 24 office visits per calendar year shall be covered for diagnosis and treatment.

(b) Each recipient shall be limited to one practitioner's care for each given diagnosis.

(c) Spinal manipulations shall be limited to neuromuscular skeletal conditions.

(d) A progress report shall be submitted to the agency after the first 60 days following the date of the first visit, and every 60 days thereafter. This report shall contain the history of the present illness, the diagnosis, the type or mode of treatment, the treatment program, and prognosis. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1981; amended May 1, 1983; amended, T-84-11, July 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended Jan. 2, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended Jan. 7, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-5-103. Scope of podiatric services. Podiatric services shall be covered for Kan Be Healthy program participants. (a) Covered services shall be diagnosis and the manual, medical, surgical or pharmaceutical treatment of those parts of the body below the ankle. Diagnosis and treatment of tendons and muscles of the lower leg as they relate to conditions of the foot shall also be covered.

(b) Surgery shall be limited to that performed on an outpatient basis.

(c) Routine foot care shall not be covered. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-12-28-89, Jan. 1, 1990; amended Jan. 7, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-5-110. Scope of partial hospitalization programs. (a) Partial hospitalization services shall be provided in a community mental health center or a facility affiliated with a community mental health center.

(b) Supportive partial hospitalization services shall be limited to a maximum of 1560 hours per medicaid recipient per calendar year.

(c) Crisis-stabilization partial hospitalization services shall be limited to a maximum of 960 hours per medicaid recipient per calendar year.

(d) Partial hospitalization services provided by state institutions shall be exempt from any limitations of hours per recipient per calendar year. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1983; amended, T-84-7, May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended July 1, 1989; amended Aug. 1, 1990; amended Oct. 28, 1991.)

30-5-114. Scope of targeted case management services. (a) Targeted case management services shall be covered for medicaid/medikan recipients.

(b) Covered services shall include the following:

(1) Referral for assessment;

(2) referral for treatment if appropriate according to the assessment; and

(3) assistance with gaining access to medically necessary services.

(c) Targeted case management services shall be provided by mental retardation centers as defined in K.S.A. 19-4001 to 19-4005, inclusive, or agencies specifically designated by a mental retardation center to provide these services to individuals who are mentally retarded or developmentally disabled. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1988; amended, T-30-1-2-90, Jan. 2, 1990; amended, T-30-2-28-90, Jan. 2, 1990; amended, T-30-6-10-91, July 1, 1991; amended Oct. 28, 1991.)

(continued)

Article 6.—MEDICAL ASSISTANCE PROGRAM—CLIENTS' ELIGIBILITY FOR PARTICIPATION

30-6-53. Financial eligibility. The following provisions are applicable to all determined eligible groups, except that subsections (c) and (d) of this regulation shall not be applicable to pregnant women and children who meet the provisions of K.A.R. 30-6-77, medicare beneficiaries who meet the provisions of K.A.R. 30-6-86, or to working disabled individuals who meet the provisions of K.A.R. 30-6-87. (a) Definitions.

(1) "Eligibility base period" means the length of time used in the determination of financial eligibility. The length of the eligibility base period varies from one month to six months, based on the living arrangement of the persons in the assistance plan.

(2) "Spenddown" means the amount of applicable income that exceeds the protected income level in the eligibility base period and that is available to meet medical costs.

(3) "Patient liability" means the amount the individual is required to pay towards the cost of care which the individual received in an institutional arrangement. It is based on the amount of applicable income that exceeds the protected income level in the eligibility base period.

(b) Establishing the eligibility base period. For prior eligibility, the base period shall be the three months immediately preceding the month of application. The application base period shall begin on the first day of the month in which the application was received. Subsequent eligibility base periods for recipients shall begin on the first day of the month following the expiration of the previous base period. Any reapplication received outside of a previously established eligibility base shall be treated as a new application without regard to any previous eligibility base. However, if the reapplication includes a request for prior eligibility, the base period of prior eligibility shall not extend into a previously established base. The eligibility base period shall not exceed six months.

(c) Establishing financial eligibility for persons in independent living and home- and community-based services arrangements.

(1) Total applicable income to be considered in the eligibility base period shall be compared to the protected income level for the base period. If the total applicable income is less than the protected income level and the individual owns property which has value within the allowable limits, the individual shall be financially eligible for medical assistance. If total applicable income exceeds the protected income level and the individual owns property which has value within the allowable limits, the excess applicable income shall be the spenddown.

(2) Each applicant or recipient shall incur allowable medical expenses in an amount at least equal to the spenddown before becoming eligible for assistance. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet the spenddown, except for medical expenses paid by a public program of the state other than medicaid.

(3) A previously unconsidered increase in total applicable income during the current eligibility base period which results in additional spenddown shall not alter the base period. The additional spenddown shall be met by the individual during the eligibility base period before the individual becomes eligible or re-eligible for medical assistance. Payments made through the program within the current eligibility base period shall not be considered to be overpayments if a previously eligible individual fails to meet the additional spenddown within the current eligibility base period.

(d) Establishing financial eligibility for persons in institutional arrangements.

(1) An individual shall be financially eligible for medical assistance for payment of nursing facility care if:

(A) Property owned is within allowable limits; and

(B) total monthly gross income does not exceed 300% of the one-person benefit level in the federal supplemental security income (SSI) program. This income provision shall not be applicable to any recipient in a nursing facility as of September 1, 1991 whose gross income exceeds 300% of the one-person SSI benefit level on that date, if the recipient continues to reside in such an arrangement and otherwise remains financially eligible for assistance. Persons who are ineligible under this provision may be eligible for medicial assistance for other than nursing facility care. In such a case, eligibility shall be based on the provisions for persons in independent living arrangements.

(2) Once financial eligiblity has been determined, the applicable income to be considered in the eligibility base period shall then be compared to the protected income level for the base period. Income in excess of the protected income level shall be the patient liability. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet this liability, except for medical expenses paid by a public program of the state other than medicaid. Any increase in total applicable income during the current eligibility base period may result in financial ineligibility or in additional liability, but shall not alter the base period. Payments made through the program within the current eligibility base period shall not be considered to be overpayments if a previously eligible individual becomes ineligible because of the increase or fails to meet the additional liability within the current eligibility base period.

(e) Allowable expenses. The following expenses shall be allowable against the spenddown or patient liability when the individual provides evidence that the individual has incurred or reasonably expects to incur the expenses within the appropriate eligibility base period, or has incurred and is still obligated for expenses outside of the appropriate eligibility base period which have not been previously applied to a spenddown or liability;

(1) Co-pay requirements;

(2) the pro rata portion of medical insurance premiums for the number of months covered in the eligibility base period regardless of the actual date of payment, past or future;

(3) medicare premiums which are not covered by

buy-in. Premiums which are subject to buy-in shall not be allowable, even if the individual pays them, or if the premiums are withheld, before completion of the buy-in process;

(4) if medically necessary, and recognized under Kansas law, all expenses for medical services incurred by the individual or a legally responsible family group member. Expenses for social services designated as medical services under the home and community based services (HCBS) program shall be allowable under this paragraph for persons in the HCBS program; and

(5) the cost of necessary transportation by appropriate mode to obtain medical services set forth in paragraph (4) above. The effective date of this regulation shall be October 28, 1991. (Authorized by K.S.A. 1990 Supp. 39-708c; implementing K.S.A. 1990 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-11, June 17, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1987; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended July 1, 1989; amended, T-30-7-2-90, July 2, 1990; revoked, T-30-8-14-90, Oct. 1, 1990; amended Oct. 1, 1990; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

30-6-74. This rule and regulation shall expire on October 28, 1991. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1988 Supp. 39-709, as amended by L. 1989, Ch. 125, Sec. 1; effective May 1, 1981; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-5, May 1, 1986; amended May 1, 1987; amended, T-88-59, Dec. 16, 1987; amended May 1, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended April 1, 1990; revoked, T-30-8-9-91, Aug. 30, 1991; revoked Oct. 28, 1991.)

30-6-106. General rules for consideration of resources, including real property, personal property, and income. (a) Legal title shall determine ownership for assistance purposes. In the absence of legal title, possession shall determine ownership.

(b) Resources, to be real, shall be of a nature that the value can be defined and measured. The objective measures set forth in paragraphs (1) and (2) below shall establish the resources' value.

(1) Real property. The value of real property shall be initially determined by the latest uniform statewide appraisal value of the property, which shall be adjusted to reflect current market value. If the property has not been appraised or if the market value as determined above is not satisfactory to the applicant, recipient, or agency, an estimate or appraisal of its value shall be obtained from a disinterested real estate broker. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(2) Personal property. The market value of personal property shall be initially determined using a reputable trade publication. If a publication is not available, or if there is a difference of opinion regarding the value of the property between the agency and the individual, an estimate from a reputable dealer shall be used. The cost of obtaining an estimate or appraisal shall be borne by the agency.

(c) (1) Resources shall be considered available both when actually available and when the applicant or recipient has the legal ability to make them available. A resource shall be considered unavailable when there is a legal impediment that precludes the disposal of the resource. The applicant or recipient shall pursue reasonable steps to overcome the legal impediment unless it is determined that the cost of pursuing legal action would be more than the applicant or recipient would gain or the likelihood of succeeding in the legal action would be unfavorable to the applicant or recipient.

(2) For the purpose of this subsection, a revocable or irrevocable trust shall be considered available to the applicant or recipient up to the maximum value of the funds which may be made available under the terms of the trust on behalf of the applicant or recipient if:

(A) The trust is established by the applicant, the recipient, the applicant or recipient's spouse, or the applicant or recipient's guardian or legal representative who is acting on the applicant or recipient's behalf;

(B) that applicant or recipient is a beneficiary; and

(C) the trustees are permitted to exercise any discretion with respect to distribution to the applicant or recipient.

This provision shall not be applicable if the applicant or recipient is a mentally retarded individual who is residing in an intermediate care facility for the mentally retarded, provided the trust was established prior to April 7, 1986 and is solely for the benefit of that applicant or recipient.

(3) For SSI, real property shall be considered unavailable for so long as it cannot be sold because:

(A) The property is jointly owned and its sale would cause undue hardship due to the loss of housing for the other owner or owners; or

(B) the owner's reasonable efforts to sell the property have been unsuccessful.

(d) The resource value of property shall be that of the applicant's or recipient's equity in the property. Unless otherwise established, the proportionate share of jointly-owned real property and the full value of jointly-owned personal property shall be considered available to the applicant or recipient. Resources held jointly with a non-legally responsible person may be excluded from consideration if the applicant or recipient can demonstrate that the applicant or recipient has no ownership interest in the resource, has not contributed to the resource, and that any access to the resource by the applicant or recipient is limited to those duties performed while the applicant or recipient is acting as an agent for the other person.

(e) Nonexempt resources of all persons in the assistance plan and the nonexempt resources of persons who have been excluded from the assistance plan pursuant to K.A.R. 30-6-74(b) and 30-6-79(c) shall be considered.

(f) (1) The combined resources of husband and wife, if they are living together, shall be considered in determining eligibility of either or both for the medical assistance program, unless otherwise prohibited by law.

(continued)

(2) A husband and wife shall be considered to be living together if they are regularly residing in the same household. Temporary absences of either the husband or the wife for education, training, working, securing medical treatment or visiting shall not interrupt the period of time during which the couple is considered to be living together.

(3) A husband and wife shall not be considered to be living together when they are physically separated and not maintaining a common life, or when one or both enter into an institutional living arrangement, including either a medicaid-approved or non-approved medical facility or a home- and community-based services care arrangement. If only one spouse enters an institutional living arrangement, the provisions of subsection (m) below apply. If both spouses enter an institutional living arrangement, the combined resources of the husband and wife shall be considered available to both for the month in which the institutional arrangement begins.

(g) The resources of an ineligible parent shall be considered in determining the eligibility of a minor child for the medical assistance program if the parent and child are living together, except that such resources shall not be considered for children in an institutional or home- and community-based services arrangement beginning with the month following the month the arrangement begins.

(h) When any individual in the household who does not have the responsibility to support a person in the plan voluntarily and regularly contributes cash to the recipient toward household expenses, including maintenance costs, the amount of the contribution to be counted shall be the net income realized by the household.

(i) Despite subsections (e), (f), and (g) above, the resources of an SSI beneficiary shall not be considered in the determination of eligibility for medical assistance of any other person.

(j) The conversion of real and personal property from one form to another shall not be considered to be income to the applicant or recipient, except for the proceeds from a contract for the sale of property.

(k) Income shall not be considered to be both income and property in the same month.

(l) Despite subsection (e) above, the resources of a child whose needs are met through foster care payments shall not be considered.

(m) When one spouse enters an institutional living arrangement and the other spouse remains in the community, and an application for medical assistance is made on behalf of the institutionalized spouse, the following provisions apply:

(1) The separate income of each spouse shall not be considered available to the other beginning in the month the institutional arrangement begins. Unless otherwise established, 1/2 of the income which is paid in the names of both spouses shall be considered available to each. Income which is paid in the name of either spouse, or in the name of both spouses and the name of another person or persons, shall be considered available to each spouse in proportion to the spouse's interest, unless otherwise established.

(2) A monthly income allowance for the community spouse shall be deducted from the income of the institutionalized spouse in determining the amount of patient liability for persons in institutionalized living arrangements or spenddown for persons in home- and community-based services arrangements. The income allowance for the community spouse, when added to the income already available to that spouse, shall not exceed 133% of the official federal poverty income guideline for two persons plus the amount of any excess shelter allowance. The excess shelter allowance is defined as the amount by which the community spouse's expenses for rent or mortgage payments, taxes and insurance for the community spouse's principal residence, plus the $175.00 food stamp standard utility allowance, exceeds 30% of the 133% federal poverty income guideline amount referred to above. The maximum income allowance which can be provided under this provision shall be $1,662.00. The $1,662.00 limitation shall be increased annually to reflect the percentage increase in the consumer price index for all urban consumers. If a greater income allowance is provided under a court order of support or through the fair hearing process, that amount shall be used in place of the above limits.

(3) A monthly income allowance for each dependent family member shall also be deducted from the income of the insitutionalized spouse in determining the amount of patient liability for persons in institutional living arrangements or spenddown for persons in home- and community-based services arrangements. A dependent family member is defined as a minor or dependent child, dependent parent or dependent sibling of either spouse who lives with the community spouse. The allowance for each member shall be equal to 1/3 of the 133% of the official federal poverty income guideline for two persons. An allowance shall not be provided if the family member's gross income is in excess of the 133% federal poverty income guideline for two persons.

(4) If the spouse is institutionalized on or after September 30, 1989, the real and personal property of both spouses shall be considered in determining the eligibility of the institutionalized spouse in the month of application, based on the amount of property in excess of the community spouse property allowance as set forth in paragraph (m) (6) below. Following the month in which the institutionalized spouse is determined eligible, the property of each spouse shall not be considered available to the other.

(5) If the spouse was institutionalized before September 30, 1989, the real and personal property of each spouse shall be considered available to the other in the month in which the institutional arrangement began. Thereafter, the property of each spouse shall not be considered available to the other.

(6) The institutionalized spouse may make available to the community spouse a property allowance which, when added to the property already available to the community spouse, would be equal to 1/2 of the total value of the property owned by both spouses as of the first period of continuous institutionalization beginning on or after September 30, 1989. This allowance

may not exceed $66,480.00, but shall be no less than $13,296.00. Both the $13,296.00 and $66,480.00 standards shall be increased annually to reflect the percentage increase in the consumer price index for all urban consumers. If a greater property allowance is provided under a court order of support or through the fair hearing process, that amount shall be used in place of the above limits.

(7) The amount of property received by the community spouse as a result of the property allowance determined in paragraph (m) (6) shall not be considered in determining the eligibility of the institutionalized spouse, except as provided in paragraph (m)(4) above. If the institutionalized spouse will be eligible based upon transferring sufficient property to the community spouse to equal the amount of the property allowance, the institutionalized spouse shall be given up to 90 days from the date of application to transfer the property. Additional time may be allowed for good cause. Pending disposition of the property, the institutionalized spouse shall be deemed to be temporarily eligible during this time period if all other eligibility factors are met. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, 39-709; effective May 1, 1981; amended, E-82-19, Oct. 21, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-26, Oct. 15, 1984; amended May 1, 1985; amended May 1, 1986; amended, T-87-15, July 1, 1986; amended, T-87-20, Sept. 1, 1986; amended May 1, 1987; amended, T-88-14, July 1, 1987; amended, T-88-59, Jan. 1, 1988; amended May 1, 1988; amended, T-89-13, April 26, 1988; amended, T-30-7-1-88, July 1, 1988; amended Sept. 26, 1988; amended July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended April 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; revoked, T-30-11-29-90, Jan. 2, 1991; amended Jan. 7, 1991; amended T-30-12-28-90, Jan. 2, 1991; amended, T-30-3-1-91, March 1, 1991; amended May 1, 1991; amended July 1, 1991; amended, T-30-8-9-91, Aug. 30, 1991; amended Oct. 28, 1991.)

Article 10.—ADULT CARE HOME PROGRAM OF THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

30-10-1a. Nursing facility program definitions. (a) "Inadequate care" means any act or failure to act which potentially may be physically or emotionally harmful to a recipient.

(b) "Inspection of care review and medical review of nursing facilities" means a yearly, resident-oriented review of only medicaid/medikan recipients, conducted by a team from the Kansas department of health and environment consisting of a nurse, a social worker, and a medical doctor, to determine whether those recipients' needs are being met.

(c) "Nursing facility (NF)" means a facility which has met state licensure standards and which provides health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(d) "Nursing facility for mental health" means a facility which has met state licensure standards and which provides health-related care and services, prescribed by a physician, in conjunction with recommended active treatment programming for residents with a diagnosis of mental illness or behavior disorders.

(e) "Mental retardation" means subaverage general intellectual functioning which originates in the developmental period and which is associated with impairment in adaptive behavior.

(f) "Plan of care" means a document which states the need for care, the estimated length of the program, the methodology to be used, and expected results.

(g) "Routine services and supplies" mean services and supplies that are commonly stocked for use by or provided to any resident. They are to be included in the provider's cost report.

(1) Routine services and supplies may include:

(A) All general nursing services;

(B) items which are furnished routinely to all residents;

(C) items stocked at nursing stations in large quantities and distributed or utilized individually in small quantities;

(D) routine items covered by the pharmacy program when ordered by a physician for occasional use; and

(E) items which are used by individual residents but which are reusable and expected to be available in a facility.

(2) Routine services and supplies are distinguished from non-routine services and supplies which are ordered or prescribed by a physician on an individual or scheduled basis. Medication ordered may be considered non-routine if:

(A) It is not a stock item of the facility; or

(B) it is a stock item with unusually high usage by the individual for whom prior authorization may or may not be required.

(3) Routine services and supplies shall not include ancillary services and other medically necessary services as defined in subsection (h) and also shall not include those services and supplies the resident must provide.

(4) Reasonable transportation expenses necessary to secure routine and non-emergency medical services are considered reimbursable through the medicaid per diem rate.

(h) "Ancillary services and other medically necessary services" mean those special services or supplies for which charges are made in addition to routine services. This includes oxygen. The purchase of oxygen gas shall be reimbursed to the oxygen supplier through the social and rehabilitation services' fiscal agent, or the fiscal agent may reimburse the nursing facility directly if an oxygen supplier is unavailable.

(i) "Costs related to resident care" means all necessary and proper costs, arising from arms-length transactions in accordance with general accounting rules, which are appropriate and helpful in developing

(continued)

and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27 and K.A.R. 30-10-28.

(j) "Costs not related to resident care" means costs which are not appropriate, or necessary and proper in developing and maintaining the nursing facility operation and activities. These costs are not allowable in computing reimbursable costs.

(k) "Related parties" means any relationship between two or more parties in which one party has the ability to influence another party to the transaction such that one or more of the transacting parties might fail to pursue its own separate interests fully. Related parties include parties related by family, business or financial association, and by common ownership or control. Transactions between related parties shall not be considered to have arisen through arms-length negotiations. Transactions or agreements that are illusory or a sham shall not be recognized.

(l) "Related to the nursing facility" means that the facility, to a significant extent, is associated or affiliated with, has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

(m) "Common ownership" means that any individual or organization holds 5% or more ownership or equity of the nursing facility and of the facility or organization serving the nursing facility.

(n) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(o) "Approved educational activities" means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of resident care in an institution. These activities shall be licensed when required by state law.

(p) "Net cost of educational activities" means the cost of approved educational activities less any grants, specific donations or reimbursements of tuition.

(q) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(r) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(s) "Adequate cost and other accounting information" means that the data, including source documentation, is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash pay out memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, financial and statistical records shall be maintained in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(t) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of business. These costs are intangible assets in that they represent expenditures for rights and privileges which have value to the enterprise. The services inherent in organization costs extend over more than one accounting period and should be amortized over a period of not less than 60 months from the date of incorporation.

(u) A "resident day" means that period of service rendered to a patient or resident between census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any medicaid/medikan or non-medicaid/medikan resident who was not in the home. Census-taking hours consist of 24 hours beginning at midnight.

(v) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital or nursing facility with reimbursement based on the specific type of care provided.

(w) "Twenty-four hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(x) "Representative" means legal guardian, conservator or representative payee as designated by the social security administration, or any person designated in writing by the resident to manage the resident's personal funds, and who is willing to accept the designation.

(y) "Non-working owners" means any individual or organization having 5% or more interest in the provider who does not perform a resident-related function for the nursing facility.

(z) "Non-working related party or director" means any related party as defined in K.A.R. 30-10-1a who does not perform a resident-related function for the nursing facility.

(aa) "Owner-related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a 5% or greater interest in the provider or any related party as defined in K.A.R. 30-10-1a, whether the payment is from a sole proprietorship, partnership, corporation, or non-profit organization.

(bb) "Projection status" means that a provider has been assigned a previous provider's rate for a set period of time or is allowed to submit a projected cost report. The provider shall submit an historic cost report at the end of the projection period to be used for a settlement of the interim rates and to determine a prospective rate.

(cc) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report is based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(dd) "Provider" means the operator of the nursing facility specified in the provider agreement.

(ee) "General accounting rules" mean the generally accepted accounting principles as established by the American Institute of Certified Public Accountants ex-

cept as otherwise specifically indicated by nursing facility program policies and regulations. Any adoption of these principles does not supersede any specific regulations and policies of the nursing facility program.

(ff) "Hospital-based nursing facility" means a facility that is attached or associated with a hospital. An allocation of expenditures between the hospital and the long-term care facility is required through a step-down process.

(gg) "Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report. This summary should contain the account number, a description of the account, amount of the account and on what line of the cost report it was reported.

(hh) "Agency" means the department of social and rehabilitation services. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-11. Personal needs fund. (a) At the time of admission, nursing facility providers shall furnish that resident and the representative, if any, with a written statement that:

(1) Lists all services provided by the provider, distinguishing between those services included in the provider's per diem rate and those services not included in the provider's basic rate, that can be charged to the resident's personal needs fund;

(2) states that there is no obligation for the resident to deposit funds with the provider;

(3) describes the resident's right to select one of the following alternatives for managing the personal needs fund:

(A) The resident may receive, retain and manage the resident's personal needs fund or have this done by a legal guardian, if any;

(B) the resident may apply to the social security administration to have a representative payee designated for purposes of federal or state benefits to which the resident may be entitled; or

(C) except when paragraph (B) of this subsection applies, the resident may designate, in writing, another person to act for the purpose of managing the resident's personal needs fund;

(4) states that any charge for these services is included in the provider's per diem rate;

(5) states that the provider is required to accept a resident's personal needs fund to hold, safeguard, and provide an accounting, upon the written authorization of the resident or representative, or upon appointment of the provider as the resident's representative payee; and

(6) states that, if the resident becomes incapable of managing the personal needs fund and does not have a representative, the provider is required to arrange for the management of the resident's personal funds as provided in K.A.R. 30-10-11(j).

(b)(1) The provider shall upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal needs fund. The provider may make arrangements with a federally or state insured banking institution to provide these services. However, the responsibility for the quality and accuracy of compliance with the requirements of K.A.R. 30-10-11 shall remain with the provider. The provider may not charge the resident for these services. Routine bank service charges shall be included in the provider's per diem rate and shall not be charged to the resident. Overdraft charges and other bank penalties are not allowable.

(2) The provider shall maintain current, written, individual records of all financial transactions involving each resident's personal needs fund for which the provider has accepted responsibility. The records shall include at least the following:

(A) The resident's name;

(B) an identification of resident's representative, if any;

(C) the admission date;

(D) the date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, and the balance after each transaction;

(E) receipts indicating the purpose for which any withdrawn funds were spent; and

(F) the resident's earned interest, if any.

(3) The provider shall provide each resident reasonable access to the resident's own financial records.

(4) The provider shall provide a written statement, at least quarterly, to each resident or representative. The statement shall include at least the following:

(A) The balance at the beginning of the statement period;

(B) total deposits and withdrawals;

(C) the interest earned, if any; and

(D) the ending balance.

(c) Commingling prohibited. The provider shall keep any funds received from a resident for holding, safeguarding, and accounting separate from the provider's operating funds, activity funds, resident council funds and from the funds of any person other than another resident in that facility.

(d) Types of accounts; distribution of interest.

(1) Petty cash. The provider may keep up to $50.00 of a resident's money in a non-interest bearing account or petty cash fund.

(2) Interest-bearing accounts. The provider shall, within 15 days of receipt of the money, deposit in an interest-bearing account any funds in excess of $50.00 from an individual resident. The account may be individual to the resident or pooled with other resident accounts. If a pooled account is used, each resident shall be individually identified on the provider's books. The account shall be in a form that clearly indicates that the provider does not have an ownership interest in the funds. The account shall be insured under federal or state law.

(3) The interest earned on any pooled interest-bearing account shall be distributed without reductions in one of the following ways, at the election of the provider:

(continued)

(A) Pro-rated to each resident on an actual interest-earned basis; or

(B) pro-rated to each resident on the basis of the resident's end-of-quarter balance.

(e) The provider shall provide the residents with reasonable access to their personal needs funds. The provider shall, upon request or upon the resident's transfer or discharge, return to the resident, the legal guardian or the representative payee the balance of the resident's personal needs fund for which the provider has accepted responsibility, and any funds maintained in a petty cash fund. When a resident's personal needs fund for which the provider has accepted responsibility is deposited in an account outside the facility, the provider, upon request or upon the resident's transfer or discharge, shall within 15 business days, return to the resident, the legal guardian, or the representative payee, the balance of those funds.

(f) When a provider is a resident's representative payee and directly receives monthly benefits to which the resident is entitled, the provider shall fulfill all of its legal duties as representative payee.

(g) Duties on change of provider.

(1) Upon change of providers, the former provider shall furnish the new provider with a written account of each resident's personal needs fund to be transferred, and obtain a written receipt for those funds from the new provider.

(2) The provider shall give each resident's representative a written accounting of any personal needs fund held by the provider before any change of provider occurs.

(3) In the event of a disagreement with the accounting provided by the former provider or the new provider, the resident shall retain all rights and remedies provided under state law.

(h) Upon the death of a resident, the provider shall provide the executor or administrator of a resident's estate with a written accounting of the resident's personal needs fund within 30 business days of a resident's death. If the deceased resident's estate has no executor or administrator, the provider shall provide the accounting to:

(1) The resident's next of kin;

(2) the resident's representative; and

(3) the clerk of the probate court of the county in which the resident died.

(i) The provider shall purchase a surety bond or employee indemnity bond, or submit a letter of credit or individual or corporate surety, to guarantee the security of residents' funds when the amount in the aggregate exceeds $1,000.00. The guarantee requirement shall not exceed the highest quarterly balance from the previous year.

(j) If a resident is incapable of managing the resident's personal needs fund, has no representative, and is eligible for SSI, the provider shall notify the local office of the social security administration and request that a representative be appointed for that resident. If the resident is not eligible for SSI, the provider shall refer the resident to the local agency office, or the provider shall serve as a temporary representative payee for the resident until the actual appointment of a guardian or conservator or representative payee.

(k) Resident property records.

(1) The provider shall maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the provider by the resident.

(2) The property record shall be available to the resident and the resident's representative.

(l) Providers shall keep the funds in the state of Kansas.

(m) Personal needs funds shall not be turned over to any person other than a duly accredited agent or guardian of the resident. With the consent of the resident, if the resident is able and willing to give consent, the administrator shall turn over a resident's personal needs fund to a designated person to purchase a particular item. However, a signed, itemized, and dated receipt shall be required for deposit in the resident's personal needs fund envelope or another type of file.

(n) Receipts shall be signed by the resident, legal guardian, conservator or responsible party for all transactions. Recognizing that a legal guardian, conservator or responsible party may not be available at the time each transaction is made for or on behalf of a resident, the provider shall have a procedure which includes a provision for signed receipts at least quarterly.

(o) The provider shall provide and maintain a system of accounting for expenditures from the resident's personal needs fund. This system shall follow generally accepted accounting principles and shall be subject to audit by representatives of the agency. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-15b. Financial data. (a) General. The per diem rate or rates for providers participating in the medicaid/medikan program shall be based on an audit or desk review of the costs reported to provide resident care in each facility. The basis for conducting these audits or reviews shall be the adult care home financial and statistical report. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the nursing facility and related fields shall be followed, except to the extent that they may conflict with or be superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Pursuant to K.A.R. 30-10-17, cost reports shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting rules, shall be based on the actual basis of accounting, and may include a current use value of the provider's fixed assets used in resident care. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 30-10-17.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that may be necessary:

(A) To assure proper payment by the program pursuant to paragraph (2);

(B) to substantiate claims for program payments; and

(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall include:

(A) Matters of the nursing facility ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other recordkeeping systems;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale or other action;

(E) franchise or management arrangements;

(F) matters pertaining to costs of operation;

(G) amounts of income received, by source and purpose; and

(H) a statement of changes in financial position.

(3) Other records and documents shall be made available as necessary.

(4) Records and documents shall be made available in Kansas.

(5) Each provider, when requested, shall furnish the agency with copies of resident service charge schedules and changes thereto as they are put into effect. The charge schedules shall be evaluated by the agency to determine the extent to which they may be used for determining program payment.

(6) Suspension of program payments may be made if the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program, or the provider fails to furnish requested records and documents to the agency. Payments to that provider may be suspended.

(7) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payments. The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(8) All records of each provider that are used in support of costs, charges and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records used to support cost reports shall be retained for five years after the date of filing the cost report with the agency. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-17. Cost reports. (a) Historical cost data.

(1) (A) For cost reporting purposes, each provider shall submit the adult care home financial and statistical report in accordance with the instructions included in this regulation. The report shall cover a consecutive 12-month period of operations. The 12-month period shall coincide with the fiscal year used for federal income tax or other financial reporting purposes, except that the same 12-month period shall be used by providers related through common ownership, common interests or common control.

(B) In accordance with paragraph (2) below, all providers shall file a 12-month cost report for the calender year ending December 31, 1991. Calender year-end cost reports shall replace the fiscal year used for federal income tax or other financial reporting purposes, beginning with the calendar year ending December 31, 1991, 1991.

(C) If the operator of a facility under a management agreement has not signed a provider agreement, the operator shall not be considered a provider for the purpose of this paragraph.

(D) A working trial balance, as defined in K.A.R. 30-10-1a, shall be submitted with the cost report.

(2) All providers who have operated a facility for 12 or more months as of December 31, 1991 shall be required to file the adult care home financial and statistical report on a calendar year basis beginning with calendar year 1991.

(b) Amended cost reports. Amended cost reports revising cost report information previously submitted by a provider shall be required when the error or omission is material in amount and results in a change in the provider's rate of $.10 or more per resident day. Amended cost reports shall also be permitted when the error or omission affects the current or future accounting periods of the provider. No amended cost report shall be allowed after 13 months have passed since the last day of the year covered by the report.

(c) Due dates of cost reports.

(1) Cost reports shall be received by the agency no later than the close of business on the last day of the third month following the close of the period covered by the report.

(2) Calendar year cost reports shall be received no later than the close of business on the last day of February following the year covered by the report.

(continued)

(3) Cost reports from each provider with more than one facility shall be received on the same date.

(d) Extension of time for submitting a cost report to be received by the agency.

(1) A one-month extension of the due date for the filing of a cost report may, for good cause, be granted by the agency. The request shall be in writing and shall be received by the agency prior to the due date of the cost report. Requests received after the due date shall not be accepted.

(2) A written request for a second extension may be granted by the secretary when the cause for further delay is beyond the control of the provider.

(3) Each provider who requests an extension of time for filing a cost report to delay the effective date of the new rate, which is lower than the provider's current rate, shall have the current rate reduced to the amount of the new rate. The reduced rate shall be effective on the date that the new rate would have been effective if the cost report had been received on the last day of the filing period without the extension.

(e) Penalty for late filing. Except as provided in subsection (d), each provider filing a cost report after the due date shall be subject to the following penalties.

(1) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be withheld and suspended until the complete adult care home financial and statistical report has been received.

(2) Failure to submit cost information within one year after the end of the provider's fiscal year shall be cause for termination from the medicaid/medikan program.

(f) Projected cost data.

(1) Projected cost reports for providers.

(A) If a provider is required to submit a projected cost report under subsection (c), (d) or (g) of K.A.R. 30-10-18, the provider's rate or rates shall be based on a proposed budget with costs projected on a line item basis for the provider's most immediate future 12-month period.

(B) The projection period shall end on the last day of a calendar month. Providers shall use the last day of the month nearest the end of the 12-month period specified in subparagraph (A) or December 31st when that period ends not more than one month before or after the end of the 12-month report period. The projection period shall not be less than 11 months or more than 13 months. The cost data reported shall be for the full period reported if that period is less than 12 months, or the latest consecutive 12-month period if the report period is extended beyond 12 months to meet this requirement.

(C) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency before the rate or rates are established for the projection period, and upon receipt of the provider's historical cost report for the time period covered by the projected cost report. The projected cost report items which are determined to be unreasonable or which contain deviations from the historical cost report shall, upon audit, be handled in accordance with subsection (e) of K.A.R. 30-10-18.

(2) The projection period of each provider filing a projected cost report in accordance with subsection (c) and paragraph (2) of subsection (d) of K.A.R. 30-10-18 shall be extended to the last day of the 12th month following the date the new provider is certified by the appropriate agency. The projected and historical cost reports for this projection period shall be handled in accordance with paragraph (1) of this subsection.

(3) Projected cost reports for each provider with more than one facility. Each provider required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in-state or out-of-state, shall allocate central office costs to each facility being paid rates from the projected cost data at the end of the provider's fiscal or calendar year that ends during the projection period. The method of allocating central office costs to those facilities on projection status shall be consistent with the method used to allocate such costs to those facilities in the chain who are filing historical cost reports.

(4) An interim settlement, based on a desk review of the historical cost report for the projection period, may generally be determined within 90 days after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on an audit of the historical cost report.

(g) Balance sheet requirement. A balance sheet prepared in accordance with cost report instructions shall be filed as part of the cost report forms for each provider. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information supplied by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers and percentile maximums, except where there are special level of care facilities approved by the United States department of health and human services.

(A) The cost centers and percentile limits shall be as follows:

(i) Administration - 75th percentile;

(ii) property - 85th percentile;

(iii) room and board - 90th percentile; and

(iv) health care - 90th percentile.

(B) The property cost center maximum shall consist of the plant operating costs and an adjustment for the real and personal property fees.

(C) The percentile limits are determined from an annual array of the most recent historical costs of each provider in the data base.

(3) To establish a per diem rate for each provider,

a factor for incentive, historical inflation, and estimated inflation shall be added to the allowable per diem cost. Other factors for the minimum wage adjustment and the federal omnibus budget reconciliation act requirements may be added to the per diem rate, when determined by the agency. After the rate is established for a provider, a detailed listing of the computation of that rate shall be provided to the provider. The effective date of the rate for existing facilities shall be in accordance with K.A.R. 30-10-19.

(b) Comparable service rate limitations.

(1) Nursing facility. The per diem rate for nursing facility care shall not exceed the rate or rates charged for the same types of services to residents not under the medicaid/medikan program.

(2) Nursing facilities for mental health. The per diem rate for nursing facilities for mental health shall not exceed the rate or rates charged for the same level of care in the nursing facility for mental health and for the same types of services to residents not under the medicaid/medikan program.

(3) All private pay rate structure changes and the effective dates shall be reported on the uniform cost report.

(4) The agency shall be notified of any private pay rate structure changes within 30 days of the effective date.

(5) Providers shall have a grace period to raise the rate or rates charged for the same types of services to residents not under the medicaid/medikan program.

(A) The grace period shall end the first day of the third calendar month following notification of a new medicaid/medikan rate.

(B) The notification date is the date typed on the letter which informs the provider of a new medicaid/medikan rate.

(C) There shall be no penalty during the grace period if the rate or rates charged to residents not under the medicaid/medikan program are lower than the medicaid/medikan rate and are subsequently increased to meet or exceed the medicaid rate.

(D) If the rate or rates charged to residents not under the medicaid/medikan program are lower after the grace period, the medicaid/medikan rate will be lowered beginning with the effective date of the medicaid rate.

(c) Rates for new construction. The per diem rate or rates for newly constructed nursing facilities shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17. No rate shall be paid until an adult care home financial and statistical report is received.

(d) Change of provider.

(1) When a provider makes no change in the facility, number of beds or operations, the payment rate for the first 12 months of operation shall be based on the historical cost data of the previous owner or provider. The new owner or provider shall file an historical cost report within 90 days after the end of the first 12-month fiscal year of operation.

(2) The new provider may file a projected cost report when the care of the residents may be at risk because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The provisions of this subparagraph shall not apply when capital improvements, applicable to all providers, are required by new state or federal regulations.

(e) Per diem rates with errors.

(1) When per diem rates, whether based upon projected or historical cost data, are audited by the agency and are found to contain errors, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may be made when a provider has more than one facility involved in settlements.

(2) Per diem rates for providers may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of these per diem rate changes and of the audit findings shall be sent to the provider. Retroactive adjustments of rates paid during any projection period shall apply to the same period of time covered by the projected rates.

(3) Providers have 30 days from the date of the audit report cover letter to request an administrative review of the audit adjustments that result in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(f) Out-of-state providers. Rates for out-of-state providers certified to participate in the Kansas medicaid/medikan program shall be the rate or rates approved by the agency. Out-of-state providers require prior authorization by the agency.

(g) Determination of rates for nursing facility providers re-entering the medicaid program.

(1) The per diem rate for each provider re-entering the medicaid program shall be determined from:

(A) A projected cost report in those cases where the provider:

(i) Has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(ii) has not participated in the medicaid program for less than 24 months and the per diem rate to be paid is not sufficient reimbursement for providing the economic and efficient care and services required by program laws and regulations; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months, and if the per diem rate to be paid is sufficient reimbursement for providing the economic and efficient care and services required by program laws and regulations. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in accordance with this paragraph.

(2) Where the per diem rate for a provider re-entering the program is determined in accordance with

(continued)

paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-19. Rates; effective dates. (a) Effective date of per diem rates for existing facilities. The effective date of a new rate that is based on information and data in the adult care home cost report shall be the first day of the third calendar month following the month the complete cost report is received by the agency, except for the calendar year cost report in which the rate is effective the following July 1st in accordance with subsection (e).

(b) Effective date of the per diem rate for a new provider. The effective date of the per diem rate for a new provider, as set forth in subsections (c), (d), and (g) of K.A.R. 30-10-18, shall be the date of certification by the department of health and environment pursuant to 42 CFR section 442.13, effective October 1, 1985, which is adopted by reference. The interim rate determined from the projected cost report filed by the provider shall be established with the fiscal agent by the first day of the third month after the receipt of a complete and workable cost report. The effective date of the final rate, determined after an audit of the historical cost report filed for the projection period, shall be the date of certification by the department of health and environment.

(c) The effective date of the per diem rates for providers with more than one facility filing a historic cost report, in accordance with K.A.R. 30-10-17(c), shall be the first day of the third calendar month after all cost reports due from that provider have been received.

(d) The effective date for a provider filing an historic cost report covering a projection status period shall be the first day of the month following the last day of the year covered by the report. This is the date that historic and estimated inflation factors are applied in determining prospective rates.

(e) The effective date of the per diem rate for providers filing an historic cost report for calendar year 1991 shall be July 1, 1992. Each subsequent calendar year cost report shall have the per diem rate effective the following July 1st. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-23a. Non-reimbursable costs. (a) Costs not related to resident care, as set forth in K.A.R. 30-10-1a, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to non-working directors and the salaries of non-working officers;

(2) bad debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, including:

(A) Federal income and excess profit taxes, including any interest or penalties paid thereon;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property which is not used in providing covered services;

(E) taxes levied against any patient or resident and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of officers and owners;

(7) the imputed value of services rendered by non-paid workers and volunteers;

(8) utilization review;

(9) costs of social, fraternal, and other organizations which concern themselves with activities unrelated to their members' professional or business activities;

(10) oxygen;

(11) vending machine and related supplies;

(12) board of director costs;

(13) resident personal purchases;

(14) barber and beauty shop expenses;

(15) advertising for patient utilization;

(16) public relations expenses;

(17) penalties, fines, and late charges;

(18) prescription drugs;

(19) items or services provided only to non-medicaid/medikan residents and reimbursed from third party payors;

(20) automobiles and related accessories in excess of $25,000.00. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;

(21) airplanes and related expenses;

(22) therapeutic beds; and

(23) bank overdraft charges or other penalties.

(b) The following contract cost limitations under the NF-MH day activity program shall not be allowed:

(1) Recipient salaries and FICA match;

(2) all material costs, including sub-contracts;

(3) all costs related to securing contracts; and

(4) 50% of the cost of the following items:

(A) Cost of equipment lease;

(B) maintenance of equipment;

(C) purchase of small tools under $100.00; and

(D) depreciation of production equipment. The effective date of this regulation shall be October 28, 1991.

(Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1988; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Oct. 28, 1991.)

30-10-24. Compensation of owners, related parties and administrators. (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-1a, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident related expense section of the cost report.

(b) Services related to resident care.

(1) If owners with 5% or more ownership interest or related parties actually perform a necessary function directly contributing to resident care, a reasonable amount shall be allowed for such resident care activity. The reasonable amount allowed shall be the lesser of:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the resident-related services actually performed by owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner or related parties.

(2) The resident-related functions shall be limited to those functions which are normally performed by non-owner employees common to the industry and for which cost data is available. The job titles for administrative and supervisory duties performed by an owner or related party shall be limited to the work activities included in the schedule of the owner or related party salary limitations.

(3) The salary limit shall also be prorated in accordance with subsection (c) of this regulation. In no case shall the limitation exceed the highest salary limit on the civil-service-based chart.

(4) The owner or related party shall be professionally qualified for those functions performed which require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) Any liabilities established shall be paid in cash within 75 days after the end of the accounting period.

(c) Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be pro-rated. The time spent on each function within a facility or within all facilities in which they have an ownership or management interest shall be pro-rated separately by function, but shall not exceed 100% of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

(d) Reporting owner or related party compensation on cost report. Owner or related party compensation shall be reported on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of 5% or more, including employees at the central office of a chain organization, shall be considered to be owner compensation. Providers with professionally qualified owner or related party employees performing duties other than those for which they are professionally qualified shall report the cost for such duties in the administrative cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and co-administrator of that facility and to owner compensation reported in the administrative cost center of the cost report. This limitation shall apply to the salaries of the administrator and co-administrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner compensation line in the administrative cost center and shall be subject to the owner-administrator compensation limitation. All owner-administrator compensation in excess of the limitation shall be included in the administrative costs used to compute the incentive factor.

(f) Management consultant fees. Fees for consulting services provided by the following professionally qualified people shall be considered owner's compensation subject to the owner-administrator compensation limit, and shall be reported on the owner compensation line in the administrative cost center if the actual cost of the service is not submitted with the adult care home financial and statistical report:

(1) Related parties as defined in K.A.R. 30-10-1a;

(2) current owners of the provider agreement and operators of the facility;

(3) current owners of the facility in a lessee-lessor relationship;

(4) management consulting firms owned and operated by former business associates of the current owners in this and other states;

(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers and other professional people who have common ownership interests in other facilities, in this or other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to resident care. An allowance shall not be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, administrative or managerial activities performed by owners or other related parties that are not directly

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related to resident care. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991, amended Oct. 28, 1991.)

30-10-25. Real and personal property fee. (a) The agency shall determine a real and personal property fee in lieu of an allowable cost for ownership or lease expense, or both. The real and personal property fee shall equal the sum of the property allowance determined under subsection (b) and the property value factor determined under subsection (c). The fee shall be facility-specific and shall not change as a result of change of ownership or lease by providers on or after July 18, 1984. An inflation factor may be applied to the fee on an annual basis.

(b) (1) The property allowance shall include an appropriate component for:

(A) Rent or lease expense;

(B) interest expense on real estate mortgage;

(C) amortization of leasehold improvements; and

(D) depreciation on buildings and equipment, calculated pursuant to subsection (d).

(2) The property allowance shall be subject to a program maximum. The percentile limitations shall be established, based on an array of the costs on file with the agency as of July 18, 1984.

(c) The property value factor shall be computed as follows:

(1) The sum of the components under paragraph (b)(1) shall be determined for each facility, based on costs on file with the agency as of July 18, 1984. These sums shall be placed in an array, and percentile groupings shall be developed from that array.

(2) The average property allowance shall be determined for each percentile grouping under paragraph (1).

(3) The average property allowance for each percentile grouping shall be multiplied by a percentage as established by the secretary on an annual basis.

(d) (1) The depreciation component of the property allowance shall be:

(A) Identifiable and recorded in the provider's accounting records;

(B) based on the historical cost of the asset as established in this regulation; and

(C) prorated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Gains and losses on the sale of depreciable personal property shall be reflected on the cost report at the time of such sale. Trading of depreciable property shall be recorded in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets are not recognized in the year of trade but are used to adjust the basis of the newly acquired property.

(3) (A) Gains from the sale of depreciable assets while the provider participates in the medicaid/medikan program, or within one year after the provider terminates participation in the program, shall be used to reduce the allowable costs for each cost reporting period prior to the sale, subject to limitation. The total sale price shall be allocated to the individual assets sold on the basis of an appraisal by a qualified appraiser or on the ratio of the seller's cost basis of each asset to the total cost basis of the assets sold.

(B) The gain on the sale shall be defined as the excess of the sale price over the cost basis of the asset. The cost basis for personal property assets shall be the book value. The cost basis for real property assets sold or disposed of before July 18, 1984, shall be the lesser of the book value adjusted for inflation by a price index selected by the agency, or an appraisal by an American institute of real estate appraisers or an appraiser approved by the agency. The cost basis for real property assets sold or disposed of after July 17, 1984 shall be the book value.

(C) The gain on the sale shall be multiplied by the ratio of depreciation charged while participating in the medicaid/medikan program to the total depreciation charged since the date of purchase or acquisition through December 31, 1984. The resulting product shall be used to reduce allowable cost.

(4) For depreciation purposes, the cost basis for a facility acquired after July 17, 1984 shall be the lesser of the acquisition cost to the holder of record on that date, or the purchase price of the asset. The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, including legal fees, accounting fees, travel costs and the cost of feasibility studies.

(e) (1) Providers shall be allowed to request a property fee rebasing if the following capital expenditure thresholds are met for related equipment or projects, or both:

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem from the interest or depreciation, or both, from the capital expenditures shall be added to the property allowance per diem originally established.

(3) The revised property allowance shall be used to determine the property value factor. The revised property value factor shall be based on the existing arrays.

(4) Effective dates for rebased property fees:

(A) If new beds are added to a facility because of a construction project, the rebased property fee shall be effective on the date that the beds are certified by the department of health and environment.

(B) If the capital expenditure being rebased is not related to a bed size increase, the effective date of the rebased property fee shall be the first day of the month closest to the date upon which complete documenta-

tion has been received by the agency. Documentation includes:

(i) The depreciation schedule reflecting the expense;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) contractor fees; and

(vi) proof of other costs associated with the capital expenditure.

(5) A property fee rebasing shall not be allowed if the request and documentation are submitted more than one year after the property subject to the rebasing has been acquired and put into service. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-27. Central office costs. (a) Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the nursing facility. Central office costs shall not be recognized or allowed to the extent they are unreasonably in excess of similar nursing facilities in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office costs shall be limited to the actual resident-related costs of the central office.

(1) The cost of ownership or the arms-length lease expense, utilities, maintenance, property taxes, insurance, and other plant operating costs of the central or regional office space for resident-related activities shall be reported as central office costs.

(2) All administrative expenses incurred by central and regional offices shall be reported as central office costs. These include but are not limited to salaries, benefits, office supplies and printing, management consultant fees, telephones and other forms of communications, travel and vehicle expenses, allowable advertising, licenses and dues, legal, accounting, data processing, insurance, and interest expenses. The costs shall not be directed to individual facilities operated by the provider or reported on any other line of the cost report.

(3) Non-reimbursable costs in K.A.R. 30-10-23a, costs allowed with limitations in K.A.R. 30-10-23b, and the revenue offsets in K.A.R. 30-10-23c shall apply to central office costs.

(4) Estimates of central office costs shall not be allowable.

(b) Central office salary and other limitations.

(1) Salaries of employees performing the duties for which they are professionally qualified shall be allocated to the room and board and health care cost centers as appropriate for the duties performed. Professionally qualified employees include licensed and registered nurses, dietitians, and others as may be designated by the secretary.

(2) Salaries of chief executives, corporate officers, department heads, and employees with ownership interests of 5% or more shall be considered owner's compensation and shall be reported as owner's compensation in the administrative cost center. Salaries of the chief executive officers of nonprofit organizations shall also be considered owner's compensation and included in the administrative cost center.

(3) The salary of an owner or related party performing a resident-related service for which such person is professionally qualified shall be included in the appropriate cost center for that service, subject to the owner-related parties salary limitations.

(4) Salaries of all other central office personnel performing resident-related administrative functions shall be reported in the administrative cost center.

(5) All providers operating more than one facility shall complete and submit detailed schedules of all salaries and expenses incurred for each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in the cost report being considered incomplete. Methods for allocating costs to all facilities in this and other states shall be submitted for prior approval. Changes in these methods shall not be permitted without prior approval.

(6) A central office cost limit may be established by the agency within the overall administrative cost center limit.

(7) Bulk purchases by the central office staff for plant operating, room and board, and health care supplies may be allocated and reported in the appropriate cost center of each facility if sufficiently documented. Questionable allocations shall be transferred to the central office cost line within the administrative cost center. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991.)

30-10-29. Reimbursement for 24-hour nursing care. Nursing facilities and nursing facilities for mental health participating in the medicaid/medikan program shall be reimbursed for providing 24-hour nursing care subject to the following limitations: (a) Nursing facilities which are currently providing 24-hour nursing care and whose costs are included in such homes' current payment rate shall not be entitled to additional reimbursement.

(b) Nursing facilities which incur the costs of professional nurses' services for an additional shift seven days per week, but who do not have these costs included in the facility's payment rate, shall be reimbursed for these costs. Professional nurses may be registered nurses or licensed practical nurses. The additional costs of the nurses include salaries, employer payroll taxes, and related employee benefits.

(1) The reimbursement shall be limited to two additional shifts, 16 hours per day, seven days per week. Any provider may request reimbursement for an additional shift after partial compliance is met or for both shifts after full compliance is met.

(2) A reimbursement factor for 24-hour nursing care shall be provided in addition to a nursing facility's current medicaid rate and may exceed the health care cost center limit.

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(3) The per diem factor shall be determined after the required forms and documentation are submitted.

(4) Required documentation includes copies of payroll records reflecting the names of nurses hired and the nurses' salary costs.

(5) As the forms and documentation will be received after the effective date of the hiring, a retroactive rate adjustment shall be made back to the effective date of employment.

(6) Nursing facilities shall only be reimbursed once for each of the two additional shifts covered by professional nurses. If a provider loses a shift coverage after receiving the additional 24-hour nursing reimbursement factor, the costs incurred to come back into compliance shall be reflected in the cost report and per diem rate.

(7) Resident days used in the denominator of the 24-hour nursing reimbursement calculation shall be based on the actual resident days from the last adult care home financial and statistical report submitted. The resident days shall not be subject to the 85% minimum occupancy factor.

(8) The 24-hour nursing reimbursement factor shall be reduced as related expenses are reflected in the cost reports.

(9) The provision for 24-hour nursing reimbursement shall not include the cost of contract labor incurred through the use of nursing pool services or other sources. The intent of the 24-hour nursing provision is to reimburse the provider for the cost of the professional nurse hired in an employee/employer relationship. The cost of contract labor for nurses shall be an allowable cost reported in the adult care home financial and statistical report and subsequently reflected in the per diem rate, subject to upper payment limits. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-86-42, Dec. 18, 1985; effective, T-87-5, May 1, 1986; effective May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Oct. 28, 1991.)

Article 22.—LICENSING OF PSYCHIATRIC HOSPITALS; FUNDING OF COMMUNITY MENTAL HEALTH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED AND FACILITIES FOR HANDICAPPED PERSONS

30-22-1. Scope. (a) These rules and regulations shall apply to the licensing of psychiatric hospitals as authorized by K.S.A. 75-3307b, as amended, and shall apply to the setting of standards, the inspection of such hospitals, and the withdrawal of licenses for cause.

(b) Terms used herein shall have the same meaning as defined in the "act for obtaining treatment for a mentally ill person," K.S.A. 59-2901 through 59-2941, as amended. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

30-22-2. Principles to be considered in approval of application for licensing, renewal of license, or revoking of license. The following principles shall be considered in the inspection of the applying psychiatric hospital: (a) The quality of the services offered by the applying agency is determined by professional standards, and the selection of the services as to kind and extent can only be determined by the governing authority usually based upon the will of the community, the nature of the community problems, and the depth of community resources (acting together with the professional considerations).

(b) The applying agency shall be a growing, developing, social organization with different stages of differentiation and versatility dependent upon the specific local internal and community forces acting at a given point in time.

(c) Services of the applying agency may be offered to the mentally ill, the mentally retarded, persons under specific or unusual stress, or handicapped persons. Services may include those listed below offered either in an inpatient, residential setting, or an outpatient, neighborhood, or home setting.

(1) Diagnosis, evaluation, treatment, and restoration of mentally disordered or handicapped persons to an optimal level of functioning.

(2) Day care, training, education, sheltered employment necessary to improve an individual's maximum abilities leading toward total rehabilitation.

(3) Consultative and educational services to schools, courts, health and welfare and social agencies, both public and private.

(4) Training for students entering the mental health and retardation professions and continuing inservice training of mental health and retardation professionals and adjunctive personnel.

(5) Recruitment, training, and supervision of volunteer workers in the mental health related activities of the community.

(6) Informational activities directed toward the general population.

(7) Research.

(8) Interventions in society purposely directed to reduce stresses to the individual or to the community as a whole, which stresses contribute to the incidence of mental illness or mental retardation.

(9) Client information and referral, counseling, follow along, protective and other social and socio-legal services, transportation, residential and transitional centers, and recreation services, all geared toward the handicapped individuals, their families and the general public.

(d) The applying agency shall acknowledge the dignity and protect the rights of all persons within its authority to direct or regulate both personnel and clientele.

(e) The applying agency shall have an ethical and competent staff, and the recruitment practices shall provide measures to insure the hiring of personnel with these characteristics.

(f) The applying agency shall make provisions to cooperate with other community agencies within the scope of its resources and the skills of its personnel,

and within its capacities to respond to the community needs.

(g) The applying agency shall keep accurate, current, and adequate client and administrative records, and shall submit reports derived from such records as required by the licensing agency to carry out these licensing procedures.

(h) The applying agency shall have written policies and procedures covering operation of the agency, including a written policy on how the agency is related to the statewide mental health planning effort.

(i) The applying agency shall provide a physical plant which is a safe and wholesome environment fit to enhance the program.

(j) The applying agency shall plan the program and physical plant to be accessible to clientele in point of view of time, location, and transportation. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

30-22-5. Licensing of private psychiatric hospitals. Private in-patient facilities for the treatment of psychiatric patients exclusively may be licensed to offer services to the full range of psychiatric patients or to some sub-groups of psychiatric patients with mental health problems in addition to alcoholism, drug addictions, developmental disabilities or similar conditions. In the event that a hospital service is offered to a limited clientele only, the license application shall so state and the license issued shall designate the limitation of service authorized by the state department of social and rehabilitation services. The responsibility for licensing psychiatric wards of general hospitals rests with the Kansas state department of health and environment. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended Feb. 15, 1977; amended May 1, 1979; amended Oct. 28, 1991.)

30-22-6. Licensing procedure; duration and renewal of license. (a) Each application for a license shall be submitted to the director of the division of mental health and retardation services on a form provided by the department.

(b) The division shall process the application, inspect the applying agency, and prepare a report to the director. The director shall review the report and recommend approval or disapproval of the application within 60 days of filing.

(c) Upon approval of the application, a license shall be issued by the department of social and rehabilitation services, stating the activity or activities for which the applicant receives the license.

(d) A license shall remain in effect for the period of two years, unless revoked for cause.

(e) Application for renewal of a license shall be submitted to the director of the division of mental health and retardation services 45 days before expiration of the license. This provision may be waived by the director upon a showing of good cause by the agency. (Authorized by and implementing K.S.A. 75-3307b; effective, E-70-16, Feb. 13, 1970; effective Jan. 1, 1971; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; amended Oct. 28, 1991.)

30-22-11 to 30-22-14. (Authorized by K.S.A. 75-3304, K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; implementing K.S.A. 19-4001, K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1987; revoked Oct. 28, 1991.)

30-22-15 to 30-22-28. (Authorized by K.S.A. 1985 Supp. 75-3307b, as amended by L. 1986, Ch. 324, Sec. 2; effective May 1, 1987; revoked Oct. 28, 1991.)

Article 46.—CHILD ABUSE AND NEGLECT

30-46-13. Right to interview. Each alleged perpetrator shall have an opportunity to be interviewed before a finding is issued identifying a perpetrator under K.A.R. 30-46-15. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, K.S.A. 1990 Supp. 65-516, as amended by L. 1991, Ch. 185; effective Jan. 2, 1989; amended Oct. 28, 1991.)

30-46-14. This rule and regulation shall expire on October 28, 1991. (Authorized by and implementing K.S.A. 39-708c, K.S.A. 1987 Supp. 65-516, as amended by L. 1988, Ch. 232, Sec. 10, L. 1988, Ch. 140; effective Jan. 2, 1989; revoked Oct. 28, 1991.)

30-46-15. Notice of decision. The alleged perpetrator shall be notified in writing of the agency decision. The notice shall set forth the reasons for the finding and shall inform the confirmed perpetrator of the perpetrator's right to appeal the decision within 30 calendar days from the date the notice was personally delivered or mailed to the perpetrator, in accordance with K.A.R. 30-7-26, et seq. The effective date of this regulation shall be October 28, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c, K.S.A. 1990 Supp. 65-516, as amended by L. 1991, Ch. 185; effective Jan. 2, 1989; amended Oct. 28, 1991.)

Article 60.—LICENSING OF COMMUNITY MENTAL HEALTH CENTERS

30-60-1. Scope. The regulations set forth in this article shall govern the licensing of community mental health centers, including those organized as mental health centers pursuant to the provisions of K.S.A. 19-4001, et seq., as amended, or organized as mental health clinics pursuant to the provisions of K.S.A. 65-211, et seq., as amended. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-2. Definitions. Words and phrases used in this article not defined herein shall have the same meanings as defined in the "treatment act for mentally ill persons," K.S.A. 59-2901, et seq., as amended, or in the "mental health reform act," K.S.A. 1990 Supp. 39-1601, et seq., and any amendments thereto. (a)

(continued)

"Center" means a community mental health center organized pursuant to the provisions of K.S.A. 19-4001, et seq., as amended, or K.S.A. 65-211, et seq., as amended.

(b) "Target population" means:

(1) Adults with severe and persistent mental illness;

(2) children and adolescents with severe emotional disabilities or disorders; or

(3) other individuals at risk of requiring institutional care for mental illness.

(c) "Adult with severe and persistent mental illness" means one who:

(1) Has a severe disability resulting from mental illness evidenced by the fact that the person has:

(A) Required inpatient hospitalization for psychiatric care and treatment more intensive than outpatient more than once in their lifetime; or

(B) experienced at least one episode of disability requiring continuous, structured, supportive residential care, other than in-patient hospitalization, lasting for at least two months; and

(2) has impaired functioning evidenced by at least two of the following, occurring on either a continuous or intermittent basis over a two year period of time:

(A) Being unemployed, being employed only in a sheltered setting, or having markedly limited work skills and a poor work history;

(B) requiring public financial assistance for their out-of-hospital maintenance and being unable to procure such assistance without help;

(C) showing severe inability to establish or maintain a personal social support system;

(D) requiring help in basic living skills; or

(E) exhibiting inappropriate social behavior which results in a demand for intervention by either the mental health or judicial systems.

(d) "Child or adolescent with severe emotional disabilities or disorders" means one who:

(1) Is under:

(A) The age of 18; or

(B) the age of 21 and has been receiving services continuously since prior to becoming 18 years of age that require further continuity for maximum therapeutic benefit; and

(2) has severe behavioral, emotional or social disabilities evidenced by the fact that the person has:

(A) Experienced disruptions in academic or developmental progress, or in family or interpersonal relationships, to the point that the child or adolescent:

(i) Is considered at risk for out-of-home placement; or

(ii) has been placed out of their home;

(B) experienced episodes of behavioral, emotional or social disability that:

(i) Have continued for an extended period of time; or

(ii) are judged, based on a specific diagnosis made by a qualified professional, likely to continue for an extended period of time;

(C) experienced behavioral, emotional or social disabilities that cannot be attributed solely to physical, sensory or intellectual deficits; or

(D) frequently required intensive, well-coordinated, supportive services developed by an interdisciplinary team involving mental health professionals.

(e) "Commissioner" means the commissioner of mental health and retardation services.

(f) "Division" means the division of mental health and retardation services within the department of social and rehabilitation services.

(g) "Secretary" means the secretary of social and rehabilitation services. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-3 and 30-6-4. Reserved.

30-60-5. Single type of license; only one issued per service area; exception. (a) Only one type of license shall be issued by the secretary to any center, that being a license to operate as a "community mental health center." To be eligible for such license a center must demonstrate that it can and will comply with all of the applicable provisions contained within this article, but not including those services and programs provided for in Article 61 which provide for those additional services and programs a center must be capable and agreeable to provide in order to be eligible to become a participating mental health center.

(b) Only one license shall be issued by the secretary to operate a "community mental health center" within the designated service area to be stated upon the license issued.

(c) Any center meeting the exception authorized by K.S.A. 75-3307b(b) shall be exempted from the limitation in subsection (b) and may continue to be licensed as a community mental health center, if it:

(1) Remains contractually affiliated with another center licensed pursuant to the provisions of this article;

(2) makes regular and timely applications for renewal of its license; and

(3) is found to be in compliance with all of the applicable provisions of this article for the services and programs it has agreed to provide in its contract of affiliation. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-6. Licensing procedure; duration and renewal of license; provisional license. (a) An application for a license or a renewal shall be submitted to the commissioner on a form prescribed by the division. An application for a renewal of a license shall be submitted at least 45 days prior to the expiration of the license. This provision may be waived by the commissioner upon a showing of good cause. Upon such waiver the commissioner may establish a reasonable deadline for submittal of a renewal application.

(b) Upon receipt of any application, a survey of the center shall be conducted by the division to determine whether the center is or will be in compliance with the requirements of this article.

(c) At any time deemed necessary by the commissioner, a licensed center may be resurveyed by the division to determine continuing compliance. Notice of the intent of the division to conduct a continuing com-

pliance survey shall be given to a center at least seven days in advance of the survey.

(d) After any licensing or compliance survey, the center shall be notified of the findings in writing. The findings of any survey which results in a decision of the secretary to deny or revoke a license may be appealed to the administrative appeals section pursuant to the provisions of article 7.

(e) A survey finding may also be to recommend the issuance of a provisional license to begin or continue operations of a center contingent upon the center developing, submitting and implementing a plan of corrective action to bring the center into compliance.

(1) This plan shall be submitted to the commissioner within 30 days following receipt of the written survey report.

(2) The division shall determine, within 30 days following receipt of a corrective action plan, whether:

(A) The plan adequately addresses the areas of noncompliance; and

(B) whether a follow-up re-survey is necessary.

(3) The results of any follow-up re-survey shall also be provided in writing and may recommend a license be issued, denied or that further corrective actions need to be taken.

(4) Failure of a center to submit or implement an approved corrective action plan may be grounds for denial or revocation of a license whether or not a provisional license has been recommended or issued.

(f) Upon receipt of a survey recommending that a license or provisional license be issued, the commissioner shall review the application for appropriateness and determine whether to issue or deny the license. Any decision to deny a license shall be made in writing and clearly state the reasons for denial. Any denial may be appealed to the administrative appeals section pursuant to the provisions of article 7.

(g) Any license issued pursuant to this article shall remain in effect for two years, unless revoked for cause.

(h) Each provisional license shall specify the length of time it shall be valid for. In no case shall a provisional license be valid for more than six months. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-7. Suspension; revocation of a license. (a) Any license issued pursuant to this article may be suspended or revoked at any time for failure to be in compliance with the applicable requirements provided for in this article.

(b) A center's license may be suspended during revocation proceedings only upon a determination by the commissioner that the continued operation of the center during revocation proceedings would constitute a serious threat to the health and safety of its clients. This determination shall be made in writing and clearly state the reasons for it.

(c) Prior to revocation of a center's license, a written notice of the proposal to revoke shall be sent to the chief executive officer of the center, by registered mail, along with a copy of the commissioner's determination to suspend the license during the revocation proceedings, if applicable. The notice shall:

(1) Clearly state the reasons for proposing revocation of the center's license; and

(2) advise the center that the proposal to revoke may be appealed to the administrative appeals section pursuant to the provisions of article 7.

(d) If at any time during the pendancy of revocation the division is satisfied that the center is in compliance with all of the applicable requirements of this article and that it is in the best interests of the public that the proposed revocation be withdrawn, the commissioner shall notify all parties to the revocation proceedings that the proposed revocation has been withdrawn and the proceedings shall be terminated.

(e) If, after notice to the center of a proposed revocation, the center does not timely appeal, the division shall revoke the license previously issued to the center. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-8 and 30-6-9. Reserved.

30-60-10. Establishment of new community mental health centers. (a) No new center may be established if its proposed service area is already being served by one or more existing licensed centers.

(b) No existing licensed center may alter its existing service area to include an area already being served by one or more existing licensed centers.

(c) A proposal to establish a new center to serve an area not otherwise served shall be accompanied by an application for a license as provided for in K.A.R. 30-60-11. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-11. Necessary elements for a proposal to establish a new center or to re-align the service area of one or more existing centers. (a) A written request for approval of the establishment of a new center, or of the re-alignment of the service area of any existing licensed center, shall be made to the commissioner and shall include:

(1) The rationale for the proposal;

(2) a specific plan for providing services to the proposed new service area;

(3) an endorsement of the proposal by the affected board or boards of county commissioners, governing boards, and chief executive officers, as appropriate:

(4) written comments received from any governmental agencies within any affected service area; and

(5) written comments received from the public and a summary of public comments made at a public hearing held for the purpose of receiving such comments. The division shall be consulted and shall have approved of the procedures utilized in obtaining such public comments.

(b) The rationale for the proposal shall include, as appropriate:

(1) How, and by whom, was the decision to create or re-align the center initiated;

(2) a description of the service area or areas to be created;

(continued)

(3) problems with the existing structure of mental health services;

(4) how a new or re-aligned center will address these problems; and

(5) an assessment of the mental health needs of the proposed new service area, including:

(A) The method of conducting the assessment;

(B) a description of the priority mental health needs of the proposed service area; and

(C) which of these needs are not being met.

(c) The service plan shall include:

(1) A description of how each of the required and other planned services will be provided;

(2) a description of how the unique mental health needs of the proposed service area will be met;

(3) evidence of establishing a working relationship with the appropriate state hospital;

(4) a plan for staffing;

(5) a description of the planned structure of governance, organization, and fiscal management, including an organizational chart of the new or re-aligned center;

(6) a long range financial plan detailing how the new or re-aligned center proposes to finance itself during an initial five-year period; and

(7) a statement of the anticipated fiscal and service impact on all affected service areas. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-12. Approval or disapproval of a proposal to establish a new community mental health center or to re-align the service area of one or more existing centers. (a) Prior to the approval or disapproval of a proposal to establish a new community mental health center, or to re-align the service area of one or more existing centers, the materials submitted and required by K.A.R. 30-60-11 shall be reviewed by the division. Additional comments from other commissions within the department of social and rehabilitation services, appropriate court personnel, consumer/client organizations or representatives, and such other persons or agencies may be received or sought out as the division deems appropriate.

(b) The commissioner shall approve or disapprove of the proposal and shall notify the applicant of that determination in writing, clearly stating the reasons why if disapproved.

(c) Any decision to disapprove may be appealed to the administrative appeals section pursuant to the provisions of article 7. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-13 to 30-60-16. Reserved.

30-60-17. Prohibition against denial of services because of inability to pay; fees; approval by the division. (a) No person requesting services from a mental health center shall be denied any services offered by the center because of an inability to pay.

(b) The fees charged for services shall be determined by the governing board of the center. These fees shall be published in a schedule of fees which shall be made available to anyone upon request. The board shall also adopt a written policy for adjusting fees according to the ability of an individual or a responsible party to pay, including the circumstances under which the fees would be waived entirely. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-18. Coordination and community involvement. (a) A center shall establish and maintain cooperative working relationships with all relevant public and private entities such as:

(1) The department of social and rehabilitation services local area office;

(2) public health departments;

(3) public and private hospitals;

(4) substance abuse programs;

(5) area education agencies;

(6) law enforcement agencies;

(7) consumer/client-oriented agencies; and

(8) other agencies as necessary to coordinate services in the community.

(b) The center's relationships to these other agencies shall be described in the center's annual needs assessment and plan required in K.A.R. 30-60-28(b).

(c) The center shall eliminate or substantially reduce physical, communication, and socio-cultural barriers to the utilization of its services.

(d) The center's location shall be readily identifiable to the public.

(e) If the enter is located in a multi-purpose facility, the center shall be identified by physical information posted within the facility sufficient to assist the public to locate the center.

(f) A brochure describing the center and its services shall be prepared and made available to residents of the service area of the center and shall be distributed to appropriate agencies who might make referrals to the center.

(g) The center's name, address and telephone numbers, including emergency service numbers, shall be on all center stationery used to communicate with its clients or members of the public.

(h) The center shall be listed in major telephone directories in the service area.

(i) If the center's emergency services number differs from the main telephone number, it shall also be separately listed in major directories and shall be distributed to local hospitals, law enforcement agencies, consumer/client and family organizations, and other appropriate agencies. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-19. Data and statistical reporting. (a) Each center shall compile and report to the division data and statistics concerning the operations of the center and its utilization by the community as the division may require.

(b) These data and statistical reporting requirements

shall be developed by the division after consultation with the association of community mental health centers and other parties as the division deems appropriate. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-20 to 30-60-24. Reserved.

30-60-25. Governing board; powers, by-laws. (a) A center shall have a governing board empowered to:

(1) Establish the mission goals of the center;

(2) adopt by-laws and policies and procedures concerning the operations of the center;

(3) adopt annual plans as required by K.A.R. 30-60-28 and the budget of the center;

(4) exercise general supervisory authority over the operations of the center, including the authority to hire, evaluate and fire the chief executive officer of the center; and

(5) function as the final authority within the center to resolve disputes over policy.

(b) If a center is established by a board or boards of county commissioners, that board or boards shall establish a separate governing board for the center, except as provided for in K.S.A. 19-4002a and K.S.A. 19-4002b.

(c) Membership of the governing board (or advisory board in accordance with the provisions of K.S.A. 19-4002a or K.S.A. 19-4002b) shall:

(1) Consist of not less than seven members;

(2) include at least one member who is or has been a consumer of mental health services, and one member who belongs to a family who has or had a consumer of mental health services;

(3) as nearly as possible, be representative of the area the center serves, and to the extent possible include members who represent:

(A) Public health agencies;

(B) the medical profession;

(C) the legal profession and the judiciary;

(D) public assistance agencies;

(E) hospitals and clinics;

(F) mental health organizations;

(G) education;

(H) rehabilitation services;

(I) labor;

(J) business;

(K) civil groups and organizations;

(L) mental health consumer organizations or advocacy groups; and

(M) the general public.

(d) The governing board shall meet at least quarterly and comprehensive minutes of all meetings of the board shall be kept.

(e) The governing board shall adopt by-laws or other policies and procedures which shall:

(1) Govern the board in its functioning;

(2) clearly set out and differentiate the responsibilities, authorities and roles of the members of:

(A) The governing board;

(B) the officers; and

(C) the staff of the center; and

(3) establish the organization and operating procedures of the center.

(f) If the center is a governmental organization or is run by a hospital, the by-laws shall include:

(1) A description of the administrative framework of the governmental agency or hospital under which the center operates; and

(2) a description of the lines of authority within the governmental agency or hospital in relation to the governing board of the center.

(g) If the center is a private non-profit corporation, it shall:

(1) Be incorporated in accordance with Kansas statute;

(2) be duly registered with the secretary of state and county register of deeds of the county wherein the center is located;

(3) in accordance with K.S.A. 19-4007, file its written contract which addresses the provisions of mental health services to the citizens of that county or counties with the board or boards of county commissioners of the county or counties it serves; and

(4) adopt by-laws which include:

(A) A delineation of the powers and duties retained by the corporation's board, its officers and any committees;

(B) a delineation of the authority and responsibilities delegated to the corporation's employed staff;

(C) the criteria for membership in the corporation, types of membership, how members are elected or appointed, the length of term of membership, and the method of filling vacancies to membership;

(D) the frequency of corporation meetings and quorum requirements;

(E) the objectives of the corporation; and

(F) other items as appropriate to demonstrate how the corporation is organized, operates and selects its officers. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-26. Conflict of interest prohibited. No member of the governing board, clinical staff or any consultant shall engage in activities constituting a conflict of interest between the center's facilities or services and the private or remunerative activities of that member, employee or consultant. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-27. Annual fiscal audit. (a) The governing board shall annually obtain an independent financial audit of the fiscal affairs of the center.

(b) The reports of this fiscal audit shall be made available to anyone upon request.

(c) A copy of the two most recent, completed fiscal audit reports shall be attached to the application for license renewal, unless previously provided to the division pursuant to any budgetary request or grant, or contract compliance requirement. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

(continued)

30-60-28. Mission goals; annual assessment; annual reports. (a) The governing board shall adopt a statement of the mission goals of the center defining, in broad terms, the purpose of the center, the population to be served, and the general nature of the services the center shall provide. From time to time the board shall review and amend this statement as appropriate.

(b) The governing board shall conduct a needs assessment annually to determine what services the community needs. These needs shall be prioritized taking into account the resources available and expected to be available to the center and the services provided by government agencies, health care providers, and social services agencies in the community. These determined needs shall be reflected in the statement of the mission goals of the center, the policies and procedures of the center, and the budget of the center, as appropriate.

(c) The governing board shall, at least annually, assess the quality and effectiveness of the services provided by the center in relationship to the mission goals of the center and the prior year's needs assessment. The board shall file an annual report of its findings with the board or boards of county commissioners of the county or counties it served and with the division. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-29 to 30-60-39. Reserved.

30-60-40. Personnel management. (a) The administrative authority of each center shall be vested in the chief executive officer, appointed by and responsible to the governing board as defined in the by-laws or policies and procedures of the center. The center's chief executive officer shall establish and maintain a program to ensure the quality, effective use, and management of the center's human resources.

(b) The medical responsibility for each client of the center shall be vested in a licensed physician. If the physician is not a psychiatrist, then a psychiatric consultant shall be made available to such physician and to other center staff assigned to work with the clients on a continuing and regularly scheduled basis.

(c) The center shall employ the number of qualified personnel in the disciplines required to meet the needs of its clients. All direct treatment services shall be provided by or under the direction of qualified staff.

(d) Professional staff shall meet the applicable state licensing, registration, and certification requirements specific to their profession.

(e) Volunteers and students having direct client contact shall be screened, trained and regularly supervised pursuant to policies and procedures which shall:

(1) Govern the scope of volunteer or student participation in the center's activities; and

(2) provide for an orientation that shall include, at least, a review of the center's policies and procedures regarding confidentiality and client rights. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-41. Personnel policies and procedures. (a) Each center shall develop and implement written personnel policies addressing the rights, duties and responsibilities of all staff of the center.

(b) These policies shall require that:

(1) A written job description be established for each position in the center, and that it be reviewed and revised on a regular basis;

(2) each employee shall receive, at least annually, a written performance evaluation based upon the duties assigned by the job description for that position; and

(3) insure that professional staff obtain and maintain the skills necessary to meet the individual needs of the center's clients.

(c) These personnel policies, including any amendments thereto, shall be made available to all staff of the center. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-42 to 30-60-44. Reserved.

30-60-45. Administrative records. (a) Accurate, current and adequate administrative and business records shall be maintained which clearly reflect the business, financial, and administrative operations of the center.

(b) These records shall be created, retained and stored pursuant to written policies and procedures of the center. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-46. Clinical records. (a) A written, consolidated, and current clinical record shall be maintained for each active client of the center.

(b) This record shall be:

(1) Developed during the course of the care and treatment of the client according to policies and procedures of the center concerning the format, organization, and content of such records;

(2) stored in a secured location with access limited to staff providing direct service to the client and to other persons only as authorized by policies of the center; and

(3) maintained according to policies and procedures of the center, including provisions for:

(A) The retention of inactive records;

(B) the destruction of obsolete records;

(C) the duplication of records; and

(D) the release of copies of records. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-47. Confidentiality and release of information. (a) A written policy and procedure shall be adopted and implemented to assure confidentiality of all information concerning individual clients of the center and shall comply with all federal, state and local laws addressing the confidentiality of that information.

(b) Information concerning individual clients of the center shall be released only as authorized by law or upon the written authorization of the individual client.

Individual authorization shall be upon a form which contains at least:

(1) The name of the individual authorizing the release of the information;

(2) the name or other information identifying the person or organization to whom the information is authorized to be released;

(3) the specific center or person being authorized to release the information;

(4) the reason or purpose for the release of the information;

(5) the specific information, or the extent or nature of the information authorized to be released;

(6) the date, event or condition upon which the authority to release such information shall expire;

(7) a provision allowing for the authorizing individual to revoke the authorization prior to its stated expiration, except for the information which has already been released pursuant to the authorization, and how such revocation may be effected;

(8) the date on which the authorization is signed; and

(9) the signature of the authorizing individual, the signature of any necessary parent, guardian or legal representative, as applicable. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-48 and 30-60-49. Reserved.

30-60-50. Client rights. (a) Each center shall adopt and implement a written policy and procedure, after consultation with organizations of consumers of mental health services, their families and advocates, which shall provide for the rights of clients who receive services from the center.

(b) Each client of the center shall be given a copy of this policy and procedure, and any additional, explanatory information necessary to assist the client in understanding the materials. Delivery of these materials to the client shall be documented in the clinical record.

(c) This policy and procedure shall contain provisions which, at the least, provide for:

(1) The right of the client to see and review the clinical record maintained on them, except that the chief executive officer of the center may refuse to disclose specific portions of the record only if the refusal is accompanied by a written statement explaining why the disclosure would be injurious to the welfare of the client;

(2) the right of the client to prevent center staff from disclosing to anyone the fact that the client has previously or is currently receiving any type of mental health treatment, or from disclosing to anyone anything the client has said or provided to center staff during any process of diagnosis or treatment; further, this right shall automatically be claimed on behalf of the client by the center unless the client expressly waives the privilege, in writing, or unless otherwise provided by law;

(3) the right of the client to an explanation of the nature of all medications prescribed, the reason for the prescription, and the most common side effects known to be associated with the medications;

(4) the right of the client to an explanation of the nature of any course of treatment prescribed, the reason for such treatment, and any known risks associated with such treatment;

(5) the right of the client to request information on possible alternative treatments;

(6) the right of voluntary clients to refuse any and all treatments prescribed;

(7) the right of involuntary clients (committed for treatment pursuant to court order) to receive an explanation of the possible legal consequences if the client fails or refuses to follow prescribed treatment or take prescribed medication;

(8) the right of the client to treatment in the least restrictive manner;

(9) the right of the client to receive services from the center in conjunction with services from a psychiatrist who is not affiliated with or on the center's staff, subject to written conditions the center may establish only to assure coordination of treatment;

(10) the right of the client to be accompanied or represented by a person of the client's own choice during all contacts with the center, subject only to a determination by center staff that the accompaniment would compromise the client's rights of confidentiality, significantly interfere with the client's treatment, or be unduly disruptive to the center's operations;

(11) the right of the client to make a complaint or file a grievance concerning a violation of any of these rights or any other matter with the chief executive officer of the center. Procedures regarding this right shall include provision for:

(A) Notification to the client of their right to make complaints or file grievances;

(B) forms on which the client can make complaints and grievances in writing;

(C) a system that will guarantee the delivery of any written complaint or grievance to the chief executive officer; and

(D) the opportunity for the client to be represented by counsel or persons of their choice during the process of filing and having determined their complaint or grievance. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-51 to 30-60-54. Reserved.

30-60-55. Quality assurance. All centers shall have the following listed ongoing quality assurance programs. Each of these quality assurance programs shall be administered pursuant to written policies and procedures which shall include specific objectives for each program and the scope within which each program shall operate. (a) Quality assessment, which shall:

(1) Be administered by a quality assessment committee, which shall:

(A) Include a physician as a member; and

(B) meet at least quarterly to review the operation of the program and any findings generated by it;

(2) include a method to assess the satisfaction of the

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center's clients with the services they received and to address any concerns or complaints the center might receive from its clients, staff or the community; and

(3) require that the records of the program be maintained.

(b) Utilization review, which shall:

(1) Be administered according to a plan which:

(A) Describes a process by which the center can monitor for and evaluate the utilization of the center's resources; and

(B) includes a method to assess the appropriateness of admissions, discharges and treatment referrals; and

(2) provide for a system of concurrent case reviews.

(c) Unusual occurrences management, which shall:

(1) Be administered according to a plan which recognizes as an unusual occurrence, at least the following specific situations:

(A) Serious injury to any client or staff member occurring at the center or during any center function or activity;

(B) any suicide or homicide involving a current or recent client of the center;

(C) significant damage to property belonging to the center, any employee of the center, or any other client of the center done by a client or recent client of the center; or

(D) any allegation of abuse of a client by any staff member of the center; and

(2) require that any actions the center may take in response to such an unusual occurrence conforms to all statutory requirements regarding the reporting of suspected crimes or abusive behaviors. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-56 to 30-60-59. Reserved.

30-60-60. Required service programs. Centers licensed pursuant to K.S.A. 75-3307b(b), as amended, are exempt from the provisions of this regulation. All other centers shall provide at least the following listed service programs. Each of these service programs shall be administered pursuant to written policies and procedures, including written criteria for admission to and discharge from the program. Each program shall also provide all applicable basic components of services required to be provided by K.A.R. 30-60-62. (a) Outpatient services, including at least:

(1) Evaluation;

(2) diagnosis;

(3) referral or liaison; and

(4) individual, group and family therapies.

(b) Medication management services, which may be provided as a separate service or included as part of outpatient services. These services shall:

(1) Be under the direction of a licensed physician;

(2) have written policies and procedures regarding medication administration, documentation, and storage, which are reviewed annually;

(3) include client education; and

(4) have written guidelines addressing routine physiological testing and evaluation of any adverse reactions.

(c) 24-hour emergency services, which shall be available to all citizens regardless of circumstances and shall include:

(1) A procedure to secure assistance for mental health emergencies 24-hours-a-day, seven-days-a-week, provided in a manner that will accommodate the needs of clients in the service area;

(2) a screening evaluation to determine the need for inpatient care, which shall be provided within 24 hours of any request for an evaluation by any individual, and provided in a manner that will accommodate the needs of clients in the service area;

(3) consultation and education services for courts, law enforcement personnel, physicians, relevant agencies and involved citizens to ensure a coordinated and appropriate delivery of emergency and screening services;

(4) a system for documented follow-up of individuals seen for emergency and screening services; and

(5) referral to outside providers, when necessary, made according to written procedures describing the center's arrangements with such organizations and professionals.

(d) Consultation, education and prevention services, which shall be provided to the citizens, professionals and agencies within the service area in a manner consistent with area needs and in accordance with center policy.

(e) Basic community support services for adults, which shall be provided either directly by the center or indirectly through one or more contracts with other licensed community mental health centers or providers. Any contracts to provide such services shall be approved by the division. The program shall:

(1) Give priority to adults within the target population meeting the following criteria in the order listed:

(A) Adults who are currently hospitalized or have recently been discharged from a psychiatric hospital;

(B) adults who are preparing for discharge from nursing facilities for mental health, group homes, and other publicly supported residential homes; and

(C) adults who may be diverted from imminent psychiatric hospitalization through community support services as determined through screening services;

(2) require these services when the client's individual treatment plan reflects the need for community support service;

(3) include client participation in the program's evaluation, development, and, where appropriate, operation; and

(4) require case management services, which shall be provided:

(A) By a case manager sufficiently qualified by education or experience, and who shall have completed a case management training program approved by the division;

(B) according to written policies providing for supervision of all case managers by supervisors who shall be qualified by education or experience and who shall have completed a case management supervision training program approved by the division;

(C) under policies assuring that no individual shall

be denied access to case management services solely on the basis of previous unsuccessful intervention;

(D) under policies assuring continuity in the relationship between the client and the case manager;

(E) under policies assuring caseloads shall be based upon the amount of support needed by the clients served by that case manager, and that no case manager's caseload shall be larger than 25 clients;

(F) under policies encouraging each case manager or team to attempt to provide the majority of their service contacts outside the mental health center facility; and

(G) under policies assuring that case management activities shall include at least:

(i) Developing and maintaining a community support network;

(ii) coordinating or assisting with emergency services during periods of client crisis;

(iii) evaluating client progress in treatment;

(iv) coordinating or providing services outlined in the individual treatment plan;

(v) assisting the client in obtaining needed benefits and services;

(vi) working with agencies to develop needed community resources for the client, including housing, employment options and income assistance;

(vii) consulting with the client's family, as appropriate;

(viii) educating clients and their support systems about severe and persistent mental illness and the community resources available to them; and

(ix) assisting the client in obtaining appropriate housing or residential services.

(f) An orientation program which may be utilized at any time during the course of services by the client, their family, or other persons whom the client may designate, to familiarize themselves with the center, its operations and policies. At a minimum, this program shall consist of a pamphlet or brochure which explains about the center, its programs, and how to obtain more information about specific subjects. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-61. Required service to target population members; denial of services to other persons. (a) No member of the target population who is a resident of the mental health center's service area shall be inappropriately denied clinically necessary mental health services by the center.

(b) If clinically necessary services are not provided by a center, the center shall refer the client for such services elsewhere and shall so inform the client. The center shall initiate and follow-up on the referral unless otherwise provided for in the client's individual treatment plan.

(c) If a center denies clinically necessary mental health services to any other person and no referral is made, written documentation describing the reasons and circumstances of the denial of services shall be prepared and provided to the person to whom services were denied and to the division. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-62. Service delivery standards. (a) Every center shall provide the following applicable basic services to each client within each program offered by the center.

(b) The provision of each applicable basic service shall be documented in and maintained as a permanent part of the clinical record for each client according to written policies and procedures adopted and implemented by the center.

(c) These basic services shall include:

(1) An intake assessment, which shall:

(A) Be performed by qualified center staff;

(B) be completed within 14 days of admission to the center;

(C) document all presenting problems, pertinent history, mental status, and a preliminary treatment plan; and

(D) document the primary intervention performed or the disposition made, or both, if applicable;

(2) an individualized treatment plan, which shall:

(A) Be developed within 30 days of the intake assessment;

(B) be developed in conjunction with the client and, where appropriate, the family of the client or other individuals designated by the client;

(C) be based on the needs identified during the intake assessment or during subsequent treatment;

(D) be coordinated during implementation by a single designated staff member where multiple services are provided; and

(E) be regularly reviewed at intervals of not later than each 180 days, sooner if indicated by the client's needs, and updated with appropriate notations in the clinical record;

(3) maintenance of a written, chronological record of the client's progress toward meeting identified goals and objectives, and which shall include documentation of each client service episode;

(4) regular review of the progress of the client with the client and, where appropriate, the family of the client or other individuals designated by the client; and

(5) a discharge plan, which shall:

(A) Include a summary document which shall be prepared within 14 days of termination of services at the center;

(B) when possible, be developed in conjunction with the client and, where appropriate, the family of the client or other individuals designated by the client;

(C) include a plan for post-discharge contact for clients from the target population; and

(D) include referrals to other services where appropriate. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-63 to 30-60-69. Reserved.

30-60-70. Optional services. The programs listed in K.A.R. 30-60-71 thru K.A.R. 30-60-76 are optional services which a center may choose to offer. If a center

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elects to provide any or all of these services, the center shall comply with the provisions of the relevant regulation as well as the provisions of K.A.R. 30-60-62. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-71. Alcohol and drug abuse programs. If a center provides specialized alcohol or drug abuse services, these services shall be: (a) Certified by the department of social and rehabilitation services' alcohol and drug abuse services commission;

(b) provided by the number of qualified staff specifically dedicated to the program necessary to meet the needs of the clients served; and

(c) administered pursuant to written policy and procedures. (Authorized by and implementing K.S.A. 75-3307b, K.S.A 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-72. Acute inpatient programs. If a center provides acute inpatient services, these services shall: (a) Be licensed separately for hospital services by either the Kansas department of health and environment, if the center is operated by a general hospital, or this department, if the center is operated as a private psychiatric hospital;

(b) be provided in the least restrictive manner following generally accepted clinical standards of practice;

(c) include both medical and nursing services;

(d) be provided by the number of qualified staff specifically dedicated to the program necessary to meet the needs of the clients served; and

(e) be administered pursuant to written policies and procedures. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-73. Partial hospitalization programs. If a center provides partial hospitalization services, these services shall: (a) Include an array of meaningful activities designed to promote reintegration of the client into the community, including:

(1) Daily living and self-care skills;

(2) socialization skills;

(3) pre-vocational skills; and

(4) recreational and leisure skills;

(b) be designed to address psychological, psychopharmacologic, interpersonal, daily living and environmental support system issues as necessary to enhance the client's initiative, independence, and feelings of self-worth;

(c) be provided by the number of qualified staff specifically dedicated to the program necessary to meet the needs of the clients served; and

(d) be administered pursuant to written policies and procedures. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-74. Residential programs. If a center provides residential services, these services shall: (a) Specifically require an assessment of the level of supervision and support necessary for the client to function in the least restrictive environment;

(b) be provided according to a plan based on that assessment and made in conjunction with the client and, where appropriate, the family of the client or other individuals designated by the client;

(c) be provided by the number of qualified staff specifically dedicated to the program necessary to assist clients maintain the residence in a safe and healthful manner; and

(d) be administered pursuant to written policies and procedures. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-75. Home-based intervention programs. If a center provides home-based intervention services, these services shall: (a) Specifically require an assessment of the additional needs of the family to enable them to cooperate with the center in providing home-based services;

(b) be provided according to a plan based on that assessment, and made in conjunction with the client and their family, and designed to:

(1) Enhance the functioning of the family; and

(2) either:

(A) Reduce the risk of placing a client out-of-home; or

(B) facilitate the successful return of the client if an out-of-home placement has already occurred;

(c) be provided by a sufficient number of qualified staff who:

(1) Are specifically dedicated to the program;

(2) have completed a home-based intervention training program which has been approved by the division; and

(3) are supervised by an appropriately qualified professional, who has completed a home-based intervention supervisory training program which has been approved by the division; and

(d) be administered pursuant to written policies and procedures which shall specifically provide for:

(1) How and from where referrals to the program shall be made;

(2) how referrals shall be screened;

(3) how therapists shall be assigned to work within the program;

(4) how caseloads shall be managed; and

(5) what conditions may be placed upon continued treatment under the program. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-60-76. Research programs. If a center conducts research programs utilizing human subjects, these programs shall: (a) Be strictly administered under written policies and procedures developed for each specific research project;

(b) require review of any project by a specifically established committee of appropriately selected personnel prior to initiation of the research;

(c) be conducted only on subjects who are capable of and who have given written, informed consent to be the subject of a specific research project;

(d) insure that progress and results of any research

project are made known to appropriate supervisory staff; and

(e) strictly adhere to any applicable professional standards regarding the conduct of research, as well as all applicable federal and state laws and regulations. (Authorized by and implementing K.S.A. 75-3307b, K.S.A 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

Article 61.—PARTICIPATING MENTAL HEALTH CENTERS

30-61-1. Scope. (a) The provisions of K.A.R. 30-61-10 shall apply to centers which have entered into contracts with the secretary pursuant to the "mental health reform act," K.S.A. 1990 Supp. 39-1601, et seq., and any amendments thereto.

(b) The provisions of K.A.R. 30-61-15 and K.A.R. 30-61-16 shall apply to these centers only if the contract they enter into with the secretary provides that the center shall provide the services covered by either or both of those sections.

(c) The provisions of K.A.R. 30-61-5 and K.A.R. 30-61-6 shall govern the process of contracting. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp.39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-2. Definitions. Words and phrases used in this article not defined herein shall have the same meanings as defined in the "treatment act for mentally ill persons," K.S.A. 59-2901, et seq., as amended, in the "mental health reform act," K.S.A. 1990 Supp. 39-1601, et. seq., and any amendments thereto, or in K.A.R. 30-60-2. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-3 and 30-61-4. Reserved.

30-61-5. Annual contracts; plan; required provisions. (a) Any center desiring to become a participating mental health center shall contract with the secretary on an annual basis. The exact term during which the center shall be considered a participating mental health center shall be specified in the contract. No obligation shall extend beyond the contract term to any subsequent years.

(b) A center desiring to become a participating mental health center shall submit a plan to the division detailing how the center would come into compliance with the provisions of applicable regulations during the contract term. The division shall review this plan and recommend to the secretary that a contract be awarded or denied.

(c) Each contract awarded shall specifically provide whether or not K.A.R. 30-61-15 or K.A.R. 30-61-16 shall apply to the center. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-6. Preference for licensed center; secretary's right to contract with other licensed centers. (a) In each service area, preference shall be given to the licensed center to enter into a contract to become the participating mental health center for that area.

(b) If a center declines to enter into a contract to become a participating mental health center, or is unwilling to enter into a contract to provide all of the services of a participating mental health center, then the secretary reserves the right to contract with another licensed center to provide the services of a participating mental health center to that area. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-7 to 30-61-9. Reserved.

30-61-10. Screening programs. (a) All participating mental health centers shall provide screening services to determine whether an individual screened:

(1) Can be evaluated or treated by community services; or

(2) must be transferred to the designated state psychiatric hospital for evaluation or treatment.

(b) This screening shall:

(1) Be performed by a qualified mental health professional utilizing the appropriate screening assessment instrument approved by the division; and

(2) provide for any protective custody necessary to implement the screening. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-11 to 30-61-14. Reserved.

30-61-15. Enhanced community support services for adults. (a) Participating mental health centers may contract with the secretary to provide enhanced community support services for adults as an extension of the services provided pursuant to K.A.R. 30-60-60(e).

(b) These services shall include:

(1) Outreach programs, including services designed to:

(A) Identify and locate individuals in the target population; and

(B) encourage these individuals to utilize the services of the center or other community resources;

(2) public education about the services available from the center;

(3) liaison services with the designated state psychiatric hospital and to nursing facilities for mental health in and near the center's service area to facilitate discharge of patients in these facilities who could be maintained in the community with the assistance of the support services provided by the center;

(4) where feasible, arranging transportation for clients who need this assistance to utilize the services of the center;

(5) where feasible, providing services at sites remote from the center to assist individuals in utilizing the center's services; and

(6) where feasible, providing or arranging other ancillary services, including communication, educational and vocational services to assist individuals in utilizing

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the center's services. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

30-61-16. Community support services for children and adolescents. (a) Participating mental health centers may contract with the secretary to provide community support services for children and adolescents.

(b) These services may be provided either directly by the center or indirectly through one or more contracts the center may enter into with other licensed community mental health centers or providers. Any contracts to provide these services shall be approved by the division.

(c) These services shall:

(1) Include consultation and support services to professionals, agencies and others within the center's service area to assist in meeting the needs of children and adolescents within that area;

(2) emphasize children and adolescents who have severe emotional disabilities or disorders and are considered to be at iminent risk for state psychiatric hospitalization or other out-of-home placement;

(3) provide liaison services between community services and the state psychiatric hospital to facilitate the return to the community of any child or adolescent from the center's service area placed ina state psychiatric hospital; and

(4) require case management services which shall be:

(A) Designed specifically to maintain children and adolescents in their homes, communities and schools whenever possible, advocating out-of-home placements only as the last resort;

(B) provided by a case manager who shall:

(i) Be sufficiently qualified by education or experience; and

(ii) have completed a case management training program approved by the division;

(C) provided according to written policies providing for supervision of all case managers by supervisors who shall:

(i) Be qualified by education or experience; and

(ii) have completed a case management supervision training program approved by the division;

(D) provided under policies assuring that no child or adolescent or their family shall be denied access to case management services solely on the basis of previous unsuccessful intervention;

(E) provided under policies assuring continuity in the relationship between the child or adolescent and the case manager;

(F) provided under policies assuring caseloads shall be based upon the amount of support needed by the children or adolescents served by that case manager, but no case manager's caseload shall be larger than 15 clients;

(G) provided under policies encouraging each case manager or team to attempt to provide the majority of their service contacts outside the mental health center facility; and

(H) provided under policies assuring that case management activities shall include at least:

(i) Developing and maintaining a community support network;

(ii) coordinating or assisting with emergency services during periods that the child or adolescent or their family is in crisis;

(iii) evaluating the child's or adolescent's progress in treatment;

(iv) coordinating or providing services outlined in the individual treatment plan;

(v) assisting the family in obtaining needed benefits and services;

(vi) working with other agencies to develop needed community resources for the family, including housing, employment options and income assistance;

(vii) consulting with the child's or adolescent's family, as appropriate;

(viii) educating the child's or adolescent's family about severe emotional disabilities and disorders and the community resources available to them and their child or adolescent; and

(ix) assisting the child's or adolescent's family in obtaining appropriate community services. (Authorized by and implementing K.S.A. 75-3307b, K.S.A. 1990 Supp. 39-1603, 39-1604(d), 39-1608(a) and (c), 65-4434(f); effective Oct. 28, 1991.)

Donna Whiteman
Secretary of Social and
Rehabilitation Services

Doc. No. 011059

INDEX TO ADMINISTRATIVE REGULATIONS

This index lists in numerical order the new, amended and revoked administrative regulations and the volume and page number of the *Kansas Register* issue in which more information can be found. This cumulative index supplements the index found in the 1991 Supplement to the *Kansas Administrative Regulations.*

AGENCY 1: DEPARTMENT OF ADMINISTRATION

Reg. No.	Action	Register
1-9-7a	Amended	V. 10, p. 382, 760

AGENCY 4: BOARD OF AGRICULTURE

Reg. No.	Action	Register
4-3-47	Amended	V. 10, p. 1319
4-3-49	Amended	V. 10, p. 1319
4-7-2	Amended	V. 10, p. 1319
4-7-510	Amended	V. 10, p. 1319
4-7-513	Amended	V. 10, p. 1319
4-7-530	New	V. 10, p. 1319
4-7-531	New	V. 10, p. 1319
4-7-532	New	V. 10, p. 1319
4-7-533	New	V. 10, p. 1320
4-7-716	Amended	V. 10, p. 1320
4-7-717	Amended	V. 10, p. 1320
4-7-722	Amended	V. 10, p. 1320
4-8-14	Revoked	V. 10, p. 1320
4-8-14a	New	V. 10, p. 1320
4-8-30	Amended	V. 10, p. 1321
4-8-39	Amended	V. 10, p. 1321
4-8-40	Amended	V. 10, p. 1321
4-13-28	New	V. 10, p. 1321
4-33-1	Amended	V. 10, p. 1315, 1321
4-33-2	New	V. 10, p. 1315, 1321

AGENCY 5: BOARD OF AGRICULTURE—DIVISION OF WATER RESOURCES

Reg. No.	Action	Register
5-23-3	Amended	V. 10, p. 1194
5-23-4a	New	V. 10, p. 1195
5-24-2	Amended	V. 10, p. 976
5-24-5	Amended	V. 10, p. 977

AGENCY 7: SECRETARY OF STATE

Reg. No.	Action	Register
7-30-1	Amended	V. 10, p. 728
7-32-1	Amended	V. 10, p. 728
7-32-2	New	V. 10, p. 728

AGENCY 9: ANIMAL HEALTH DEPARTMENT

Reg. No.	Action	Register
9-13-1 through 9-13-3	Revoked	V. 10, p. 1011
9-13-4	Revoked	V. 10, p. 257
9-18-1	Amended	V. 10, p. 1011
9-19-1	New	V. 10, p. 1011

AGENCY 14: DEPARTMENT OF REVENUE—DIVISION OF ALCOHOLIC BEVERAGE CONTROL

Reg. No.	Action	Register
14-19-24	Amended	V. 10, p. 689
14-19-36	Amended	V. 10, p. 689
14-20-25	Amended	V. 10, p. 689
14-20-26	Amended	V. 10, p. 690
14-21-9	Amended	V. 10, p. 690
14-22-6	Amended	V. 10, p. 690
14-22-9	Amended	V. 10, p. 691
14-23-4	Amended	V. 10, p. 691

AGENCY 23: DEPARTMENT OF WILDLIFE AND PARKS

Reg. No.	Action	Register
23-3-16	Revoked	V. 10, p. 916
23-8-24	Revoked	V. 10, p. 916
23-12-1	Revoked	V. 10, p. 916
23-12-8	Revoked	V. 10, p. 916
23-12-11	Revoked	V. 10, p. 917

AGENCY 25: STATE GRAIN INSPECTION DEPARTMENT

Reg. No.	Action	Register
25-4-1	Amended	V. 10, p. 405

AGENCY 26: DEPARTMENT ON AGING

Reg. No.	Action	Register
26-8-1 through 26-8-14	New	V. 10, p. 1285-1287

AGENCY 28: DEPARTMENT OF HEALTH AND ENVIRONMENT

Reg. No.	Action	Register
28-4-405	Amended	V. 10, p. 257
28-4-530	New	V. 10, p. 1246
28-4-531	New	V. 10, p. 1246
28-17-6	Amended	V. 10, p. 1246
28-17-12	Amended	V. 10, p. 1246
28-19-61	Amended	V. 10, p. 1246
28-19-62	Amended	V. 10, p. 1250
28-19-76	New	V. 10, p. 1251
28-19-77	New	V. 10, p. 1252
28-19-78	New	V. 10, p. 1254
28-53-1 through 28-53-5	New	V. 10, p. 199
28-59-1 through 28-59-8	New	V. 10, p. 111-113

AGENCY 30: SOCIAL AND REHABILITATION SERVICES

Reg. No.	Action	Register
30-4-34	Amended	V. 10, p. 956
30-4-41	Amended	V. 10, p. 692
30-4-63	Amended	V. 10, p. 1288
30-4-64	Amended	V. 10, p. 1289
30-4-90	Amended	V. 10, p. 959
30-4-101	Amended	V. 10, p. 961
30-4-111	Amended	V. 10, p. 341
30-4-112	Amended	V. 10, p. 692
30-4-113	Amended	V. 10, p. 693
30-4-120	Amended	V. 10, p. 343
30-4-130	Amended	V. 10, p. 961
30-5-58	Amended	V. 10, p. 693
30-5-77	Amended	V. 10, p. 1291
30-5-78	New	V. 10, p. 1297
30-5-79	New	V. 10, p. 1297
30-5-81	Amended	V. 10, p. 699
30-5-86	Amended	V. 10, p. 699
30-5-88	Amended	V. 10, p. 700
30-5-92	Amended	V. 10, p. 344
30-5-94	Amended	V. 10, p. 345
30-5-95	Amended	V. 10, p. 346
30-5-101	Amended	V. 10, p. 1298
30-5-103	Amended	V. 10, p. 1298
30-5-104	Amended	V. 10, p. 701
30-5-112	Amended	V. 10, p. 963
30-5-113	Amended	V. 10, p. 963
30-5-114	Amended	V. 10, p. 963
30-5-115	Amended	V. 10, p. 963
30-5-151	Amended	V. 10, p. 963
30-5-152	Amended	V. 10, p. 963
30-5-154	Amended	V. 10, p. 963
30-5-156	Amended	V. 10, p. 963
30-5-157	Amended	V. 10, p. 964
30-5-159	Amended	V. 10, p. 964
30-5-160	Amended	V. 10, p. 964
30-5-161	Amended	V. 10, p. 964
30-5-162	Amended	V. 10, p. 964
30-5-163	Amended	V. 10, p. 964
30-5-164	Amended	V. 10, p. 964
30-5-166	Amended	V. 10, p. 964
30-5-167	Amended	V. 10, p. 964
30-5-168	Amended	V. 10, p. 964
30-5-169	Amended	V. 10, p. 964
30-5-170	Amended	V. 10, p. 965
30-5-171	Amended	V. 10, p. 965
30-6-53	Amended	V. 10, p. 1298
30-6-65	Amended	V. 10, p. 346
30-6-74	Revoked	V. 10, p. 1299
30-6-77	Amended	V. 10, p. 701
30-6-82	New	V. 10, p. 702
30-6-86	Amended	V. 10, p. 348
30-6-103	Amended	V. 10, p. 702
30-6-106	Amended	V. 10, p. 1299
30-6-107	Amended	V. 10, p. 705
30-6-111	Amended	V. 10, p. 351
30-6-112	Amended	V. 10, p. 705
30-6-113	Amended	V. 10, p. 706
30-7-65	Amended	V. 10, p. 707
30-10-7	Amended	V. 10, p. 354
30-10-15a	Amended	V. 10, p. 708
30-10-16	Amended	V. 10, p. 709
30-10-29	Amended	V. 10, p. 354
30-10-30	Revoked	V. 10, p. 355
30-10-200	Amended	V. 10, p. 1198
30-10-207	Amended	V. 10, p. 1200
30-10-208	Amended	V. 10, p. 1200
30-10-210 through 30-10-226	New	V. 10, p. 48-57
30-10-210	Amended	V. 10, p. 1202
30-10-211	Amended	V. 10, p. 1203
30-10-212	Amended	V. 10, p. 1204
30-10-213	Amended	V. 10, p. 1204
30-10-214	Amended	V. 10, p. 1230
30-10-215	Amended	V. 10, p. 1206
30-10-217	Amended	V. 10, p. 1206
30-10-218	Amended	V. 10, p. 1207
30-10-219	Amended	V. 10, p. 1207
30-10-220	Amended	V. 10, p. 1208
30-10-221	Amended	V. 10, p. 1208
30-10-226	Revoked	V. 10, p. 1209
30-41-1	Amended	V. 10, p. 710
30-41-7a	Amended	V. 10, p. 711
30-41-7i	New	V. 10, p. 711
30-41-20	New	V. 10, p. 711

AGENCY 36: DEPARTMENT OF TRANSPORTATION

Reg. No.	Action	Register
36-1-1	Amended	V. 10, p. 88
36-1-28 through 36-1-34	New	V. 10, p. 88-91

AGENCY 40: KANSAS INSURANCE DEPARTMENT

Reg. No.	Action	Register
40-2-20	New	V. 10, p. 259, 383
40-3-46	New	V. 10, p. 381
40-3-47	New	V. 10, p. 381

AGENCY 44: DEPARTMENT OF CORRECTIONS

Reg. No.	Action	Register
44-6-106	Amended	V. 10, p. 1195
44-6-108	Amended	V. 10, p. 1195
44-6-114c	Amended	V. 10, p. 1196
44-6-120	Amended	V. 10, p. 1196
44-6-124	Amended	V. 10, p. 1196
44-6-126	Amended	V. 10, p. 1197
44-6-133	Amended	V. 10, p. 1197
44-6-134	Amended	V. 10, p. 1197
44-6-135	Amended	V. 10, p. 1197
44-6-142	Amended	V. 10, p. 1198

AGENCY 60: BOARD OF NURSING

Reg. No.	Action	Register
60-3-105	Amended	V. 10, p. 1040
60-3-106	Amended	V. 10, p. 1040
60-8-101	Amended	V. 10, p. 496
60-9-101	Amended	V. 10, p. 1040
60-9-102	Amended	V. 10, p. 1040
60-9-103	Amended	V. 10, p. 1041
60-9-105	New	V. 10, p. 1041
60-9-106	New	V. 10, p. 1041
60-9-109	New	V. 10, p. 1041
60-11-103	Amended	V. 10, p. 1041
60-11-110	Revoked	V. 10, p. 1042
60-11-111	Revoked	V. 10, p. 1042
60-11-112	New	V. 10, p. 1042
60-11-113	New	V. 10, p. 1042
60-11-116	New	V. 10, p. 1042
60-11-117	New	V. 10, p. 1042
60-11-118	New	V. 10, p. 1042
60-11-119	New	V. 10, p. 1043
60-12-101	Revoked	V. 10, p. 1043
60-12-102	Revoked	V. 10, p. 1043
60-12-103	Revoked	V. 10, p. 1043
60-12-105	New	V. 10, p. 1043
60-12-106	New	V. 10, p. 1043
60-12-109	New	V. 10, p. 1043
60-13-101	Amended	V. 10, p. 496
60-13-105	Revoked	V. 10, p. 1044
60-13-106	Revoked	V. 10, p. 1044
60-13-107	Revoked	V. 10, p. 1044
60-13-108	Revoked	V. 10, p. 1044
60-13-110	New	V. 10, p. 1044
60-13-111	New	V. 10, p. 1044
60-13-112	New	V. 10, p. 1044
60-13-115	New	V. 10, p. 1044
60-15-101	Amended	V. 10, p. 1045
60-15-102	Amended	V. 10, p. 1045
60-15-103	Amended	V. 10, p. 1046
60-15-104	Amended	V. 10, p. 1046

AGENCY 67: BOARD OF HEARING AID EXAMINERS

Reg. No.	Action	Register
67-3-4	New	V. 10, p. 887

AGENCY 68: BOARD OF PHARMACY

Reg. No.	Action	Register
68-7-10	Amended	V. 10, p. 1082
68-9-1	Amended	V. 10, p. 1083
68-11-1	Amended	V. 10, p. 216
68-20-15a	Amended	V. 10, p. 1084
68-20-18	Amended	V. 10, p. 1084
68-20-19	Amended	V. 10, p. 1085

AGENCY 74: BOARD OF ACCOUNTANCY

Reg. No.	Action	Register
74-2-7	Amended	V. 10, p. 840
74-4-6	Amended	V. 10, p. 841
74-5-2	Amended	V. 10, p. 841
74-5-403	Amended	V. 10, p. 842

AGENCY 81: OFFICE OF THE SECURITIES COMMISSIONER

Reg. No.	Action	Register
81-2-1	Amended	V. 10, p. 1242
81-3-1	Amended	V. 10, p. 1242
81-3-2	Amended	V. 10, p. 1244
81-4-1	Amended	V. 10, p. 1245, 1316
81-4-2	New	V. 10, p. 172
81-5-8	Amended	V. 10, p. 1245
81-6-1	Amended	V. 10, p. 173

(continued)

AGENCY 82: STATE CORPORATION COMMISSION

Reg. No.	Action	Register
82-3-101	Amended	V. 10, p. 887
82-3-307	Amended	V. 10, p. 976
82-3-600	Amended	V. 10, p. 890
82-3-600b	New	V. 10, p. 890
82-3-601	Revoked	V. 10, p. 891
82-3-601a	New	V. 10, p. 891
82-3-601b	New	V. 10, p. 891
82-3-602	Amended	V. 10, p. 891
82-3-605	New	V. 10, p. 892
82-4-1	Amended	V. 10, p. 1121
82-4-2	Amended	V. 10, p. 1121
82-4-3	Amended	V. 10, p. 1122
82-4-6a	Amended	V. 10, p. 1122
82-4-6b	Revoked	V. 10, p. 1122
82-4-6d	Amended	V. 10, p. 1122
82-4-19a	Revoked	V. 10, p. 1123
82-4-20	Amended	V. 10, p. 1123
82-4-27	Amended	V. 10, p. 1123
82-4-27a	Amended	V. 10, p. 1124
82-4-27c	Amended	V. 10, p. 1124

AGENCY 86: REAL ESTATE COMMISSION

Reg. No.	Action	Register
86-1-5	Amended	V. 10, p. 531

AGENCY 91: DEPARTMENT OF EDUCATION

Reg. No.	Action	Register
91-1-68	Revoked	V. 10, p. 1046
91-1-68a	New	V. 10, p. 1046
91-1-68b	New	V. 10, p. 1047
91-1-68c	New	V. 10, p. 1048
91-1-68d	New	V. 10, p. 1049
91-1-69	Revoked	V. 10, p. 1050
91-1-101b	Amended	V. 10, p. 1050
91-1-112a	Amended	V. 10, p. 1051
91-1-150	Amended	V. 10, p. 1051
91-10-1	Revoked	V. 10, p. 1051
91-10-1a	New	V. 10, p. 1052
91-12-22	Amended	V. 10, p. 1052
91-12-25	Amended	V. 10, p. 1055
91-12-51	Amended	V. 10, p. 1056
91-12-73	Amended	V. 10, p. 1056
91-31-7	Amended	V. 10, p. 686
91-35-1 through 91-35-4	New	V. 10, p. 909, 910
91-37-1 through 91-37-4	New	V. 10, p. 910, 911

AGENCY 92: DEPARTMENT OF REVENUE

Reg. No.	Action	Register
92-55-2a	Amended	V. 10, p. 531, 587

AGENCY 99: BOARD OF AGRICULTURE—DIVISION OF WEIGHTS AND MEASURES

Reg. No.	Action	Register
99-8-8	Amended	V. 10, p. 1322
99-8-9	Amended	V. 10, p. 1322
99-25-1	Amended	V. 10, p. 1322
99-25-2	Amended	V. 10, p. 1322
99-25-3	Amended	V. 10, p. 1322
99-30-2	Amended	V. 10, p. 1322
99-30-3	Amended	V. 10, p. 1323
99-30-4	Amended	V. 10, p. 1323
99-30-5	Amended	V. 10, p. 1323
99-30-6	Amended	V. 10, p. 1323
99-31-3	Amended	V. 10, p. 1323
99-31-4	Amended	V. 10, p. 1323
99-32-1 through 99-32-6	Revoked	V. 10, p. 1323

AGENCY 100: BOARD OF HEALING ARTS

Reg. No.	Action	Register
100-10a-4	Amended	V. 10, p. 653
100-11-1	Amended	V. 10, p. 653

AGENCY 102: BEHAVIORAL SCIENCES REGULATORY BOARD

Reg. No.	Action	Register
102-2-1a	Amended	V. 10, p. 32
102-2-2a	Amended	V. 10, p. 33
102-2-4a	Amended	V. 10, p. 34
102-2-7	Amended	V. 10, p. 34
102-2-8	Amended	V. 10, p. 36
102-2-12	Amended	V. 10, p. 36
102-3-1	New	V. 10, p. 37
102-3-3	New	V. 10, p. 37
102-3-4	New	V. 10, p. 38
102-3-5	New	V. 10, p. 38
102-3-6	New	V. 10, p. 39
102-3-10	New	V. 10, p. 40
102-3-11	New	V. 10, p. 41
102-4-4	Amended	V. 10, p. 41

AGENCY 111: THE KANSAS LOTTERY

Reg. No.	Action	Register
111-1-2	Amended	V. 7, p. 1190
111-1-5	Amended	V. 8, p. 586
111-2-1	Amended	V. 7, p. 1995
111-2-2	Amended	V. 9, p. 1675
111-2-2a	Revoked	V. 9, p. 1675
111-2-6	New	V. 8, p. 134
111-2-7	Revoked	V. 10, p. 1210
111-2-13	Revoked	V. 10, p. 881
111-2-14	New	V. 9, p. 30
111-2-15	Revoked	V. 10, p. 881
111-2-16	Revoked	V. 10, p. 1210
111-2-17	Revoked	V. 10, p. 1210
111-2-18	New	V. 10, p. 881
111-2-19	New	V. 10, p. 882
111-3-1	Amended	V. 10, p. 1210
111-3-9	Amended	V. 8, p. 1085
111-3-10 through 111-3-31	New	V. 7, p. 201-206
111-3-11	Amended	V. 8, p. 299
111-3-12	Amended	V. 10, p. 12
111-3-13	Amended	V. 10, p. 1014
111-3-14	Amended	V. 10, p. 12
111-3-16	Amended	V. 9, p. 1566
111-3-19 through 111-3-22	Amended	V. 9, p. 30
111-3-20	Amended	V. 10, p. 1211
111-3-21	Amended	V. 10, p. 882
111-3-22	Amended	V. 10, p. 882
111-3-23	Revoked	V. 10, p. 883
111-3-25	Amended	V. 10, p. 883
111-3-27	Amended	V. 10, p. 883
111-3-29	Amended	V. 10, p. 883
111-3-31	Amended	V. 8, p. 209
111-3-32	Amended	V. 10, p. 883
111-3-33	New	V. 7, p. 1434
111-4-1	Amended	V. 8, p. 134
111-4-2	Amended	V. 7, p. 1063
111-4-4	Amended	V. 7, p. 1063
111-4-6	Amended	V. 7, p. 1434
111-4-7	Amended	V. 7, p. 1945
111-4-8	Amended	V. 7, p. 1064
111-4-12	Amended	V. 7, p. 1190
111-4-66 through 111-4-77	New	V. 7, p. 207-209
111-4-96 through 111-4-114	New	V. 7, p. 1606-1610
111-4-100	Amended	V. 10, p. 1211
111-4-101	Amended	V. 10, p. 1211
111-4-102	Amended	V. 10, p. 1211
111-4-103	Amended	V. 10, p. 1211
111-4-104	Amended	V. 10, p. 1212
111-4-105	Amended	V. 10, p. 1212
111-4-106	Amended	V. 10, p. 1212
111-4-106a	Amended	V. 10, p. 1213
111-4-107	Amended	V. 9, p. 1366
111-4-108	Amended	V. 10, p. 1213
111-4-111	Amended	V. 9, p. 1366
111-4-113	Amended	V. 9, p. 1366
111-4-114	Amended	V. 9, p. 1366
111-4-153 through 111-4-160	Revoked	V. 9, p. 1676, 1677
111-4-177 through 111-4-212	Revoked	V. 9, p. 1677, 1678
111-4-213 through 111-4-220	Revoked	V. 10, p. 1213
111-4-217	Amended	V. 9, p. 986
111-4-221 through 111-4-224	New	V. 9, p. 1197
111-4-225 through 111-4-228	New	V. 9, p. 1366, 1367
111-4-229 through 111-4-236	New	V. 9, p. 1566-1568
111-4-237 through 111-4-240	New	V. 9, p. 1678, 1679
111-4-241 through 111-4-244	New	V. 9, p. 1812
111-4-245 through 111-4-248	New	V. 10, p. 200
111-4-249 through 111-4-252	New	V. 9, p. 1813
111-4-253 through 111-4-256	New	V. 10, p. 530
111-4-257 through 111-4-280	New	V. 10, p. 755-759
111-4-257	Amended	V. 10, p. 1014
111-4-261	Amended	V. 10, p. 1014
111-4-262	Amended	V. 10, p. 1014
111-4-282 through 111-4-286	New	V. 10, p. 759
111-4-287 through 111-4-300	New	V. 10, p. 883-886
111-4-301 through 111-4-307	New	V. 10, p. 1015, 1016
111-4-308 through 111-4-320	New	V. 10, p. 1214, 1215
111-5-1 through 111-5-23	New	V. 7, p. 209-213
111-5-9 through 111-5-15	Amended	V. 8, p. 210, 211
111-5-11	Amended	V. 9, p. 505
111-5-17	Amended	V. 8, p. 211
111-5-18	Amended	V. 10, p. 13
111-5-19	Amended	V. 8, p. 212
111-6-1 through 111-6-15	New	V. 7, p. 213-217
111-6-1	Amended	V. 10, p. 14
111-6-3	Amended	V. 9, p. 200
111-6-5	Amended	V. 10, p. 14
111-6-6	Amended	V. 10, p. 1216
111-6-9	Amended	V. 10, p. 1217
111-6-12	Amended	V. 8, p. 212
111-6-13	Amended	V. 8, p. 299
111-6-17	New	V. 7, p. 1191
111-7-1 through 111-7-10	New	V. 7, p. 1192, 1193
111-7-1	Amended	V. 8, p. 212
111-7-3	Amended	V. 9, p. 986
111-7-4	Amended	V. 9, p. 1367
111-7-5	Amended	V. 9, p. 986
111-7-6	Amended	V. 9, p. 987
111-7-9	Amended	V. 9, p. 1569
111-7-11	Amended	V. 9, p. 987
111-7-12 through 111-7-32	New	V. 7, p. 1194-1196
111-7-33 through 111-7-43	New	V. 7, p. 1197, 1198
111-7-33a	New	V. 8, p. 300
111-7-44 through 111-7-54	New	V. 9, p. 1367-1370
111-7-55 through 111-7-63	Revoked	V. 10, p. 1217

111-7-58	Amended	V. 10, p. 261
111-7-60	Amended	V. 10, p. 262
111-8-1	New	V. 7, p. 1633
111-8-2	New	V. 7, p. 1633
111-8-3	Amended	V. 10, p. 886
111-8-4	New	V. 7, p. 1714
111-8-4a	New	V. 7, p. 1995
111-8-5 through 111-8-13	New	V. 7, p. 1634
111-9-1 through 111-9-12	New	V. 7, p. 1714-1716
111-9-1 through 111-9-6	Revoked	V. 9, p. 1680
111-9-13 through 111-9-18	Revoked	V. 9, p. 1680
111-9-25 through 111-9-30	New	V. 9, p. 699, 700
111-9-31 through 111-9-36	New	V. 10, p. 262
111-10-1 through 111-10-9	New	V. 8, p. 136-138
111-10-7	Amended	V. 8, p. 301

AGENCY 112: KANSAS RACING COMMISSION

Reg. No.	Action	Register
112-4-14b	New	V. 10, p. 162
112-4-21	New	V. 10, p. 162
112-6-1 through 112-6-5	Amended	V. 10, p. 163-165
112-6-8	Amended	V. 10, p. 165
112-7-6	Amended	V. 10, p. 165
112-8-3	Amended	V. 10, p. 166
112-8-4	Amended	V. 10, p. 167
112-8-5	Amended	V. 10, p. 167
112-8-8	Amended	V. 10, p. 168
112-8-10	Amended	V. 10, p. 168
112-10-34	Amended	V. 10, p. 169
112-10-35	Amended	V. 10, p. 170
112-11-21	Amended	V. 10, p. 263; 531
112-12-12	Amended	V. 10, p. 170
112-13-2	Amended	V. 10, p. 170
112-13-4	New	V. 10, p. 171
112-13-5	New	V. 10, p. 171
112-16-1 through 112-16-14	New	V. 10, p. 1316-1318

AGENCY 115: DEPARTMENT OF WILDLIFE AND PARKS

Reg. No.	Action	Register
115-4-1	Amended	V. 10, p. 458
115-4-3	Amended	V. 10, p. 458
115-4-5	Amended	V. 10, p. 782
115-4-7	Amended	V. 10, p. 460
115-4-11	Amended	V. 10, p. 461
115-4-12	New	V. 10, p. 461
115-13-1 through 115-13-5	New	V. 10, p. 917-919
115-17-10 through 115-17-13	New	V. 10, p. 461, 462

AGENCY 117: REAL ESTATE APPRAISAL BOARD

Reg. No.	Action	Register
117-1-1	Amended	V. 10, p. 911, 951
117-2-1	Amended	V. 10, p. 911, 952
117-2-2	Amended	V. 10, p. 912, 952
117-2-3	New	V. 10, p. 912, 952
117-2-4	New	V. 10, p. 912, 952
117-3-1	Amended	V. 10, p. 912, 953
117-3-2	Amended	V. 10, p. 913, 953
117-3-3	New	V. 10, p. 913, 953
117-3-4	New	V. 10, p. 913, 953
117-4-1 through 117-4-4	New	V. 10, p. 913, 914, 954
117-6-1	Amended	V. 10, p. 914, 954
117-6-2	Amended	V. 10, p. 915, 955
117-6-3	Amended	V. 10, p. 915, 955
117-7-1	Amended	V. 10, p. 916, 956
117-8-1	New	V. 10, p. 916, 956
117-9-1	New	V. 10, p. 916, 956

AGENCY 119: KANSAS DEVELOPMENT FINANCE AUTHORITY

Reg. No.	Action	Register
119-1-1	New	V. 10, p. 263
119-1-2	New	V. 10, p. 264
119-1-3	New	V. 10, p. 264

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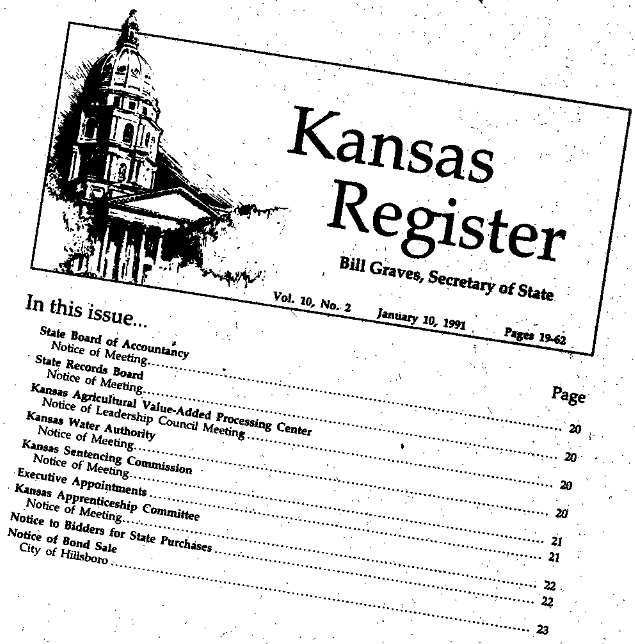
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Bill Graves, Secretary of State

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